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MEDICAL ANNALS
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THE SYNDROME OF PREMATURE VENTRICULAR EXCITATION IN WHICH THE PR INTERVAL IS SHORT AND THE QRS COMPLEX IS PROLONGED (WOLFF-PARKINSON-WHITE SYNDROME)

Report of Four Cases

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THE syndrome comprising an electrocardiographic pattern in which there is a short PR interval associated with prolongation of the QRS complex and with which are frequently found paroxysms of tachycardia was first described as a clinical entity by Wolff, Parkinson and White[1] in 1930. Other authors had previously described electrocardiograms which exhibited this alteration. Wilson[2] in 1915 ascribed the abnormal QRS complexes as due to vagal influence. Wedd[3] reported a case in 1921 and interpreted the shortened PR interval as due to A-V nodal rhythm, and the widened QRS complex as due to bundle-branch block. Four cases were described by Hamburger[4] in 1929. He also considered the mechanism to be due to bundle-branch block and nodal rhythm. Hunter, Papp and Parkinson[5] reviewed 90 cases from the literature in 1940 and added 19 cases of their own. Numerous other reports have appeared during the past 5 years.[6–25]

Interest in the syndrome has been widespread, not because of the importance of its clinical recognition, but rather because of the anatomic-physiologic implications concerning its production and because it must be differentiated from bundle-branch block and occasionally from coronary arteriosclerotic heart disease.[6, 9] The prognosis of paroxysms of tachycardia occurring in this condition is the same as for paroxysms of tachycardia in individuals without heart disease. However, the incidence of paroxysms is greater with persons showing this syndrome than for those exhibiting no electrocardiographic abnormalities.

This syndrome is distinct as a clinical entity for the following reasons: 1. The PR interval is shortened to 0.12 second or less. 2. The QRS wave is widened to 0.10 second or more, but in contrast to bundle-branch block the increased duration of this ventricular complex is at the expense of the isoelectric period following the P wave and ending with the onset of the QRS. This is readily evident if abnormal P-QRS and normal P-QRS combinations are found in the same patient or in the same tracing; the PS interval (distance from the onset of the P wave to the ending of the QRS) is constant in both instances. This was originally pointed out by Wolferth and Wood.[13] 3. The upstroke of the QRS wave is slurred mainly at its onset. The gradient of rise of the first limb of the QRS is more gradual as compared with its offset, so that the peak of R_1 and R_2 (when QRS is entirely upright) or S_1 and S_2 (when QRS_1 is diphasic or mainly inverted) is longer than from the peak to the end of the QRS complex. 4. Most cases have been associated with paroxysms of tachycardia, the majority of which are supraventricular, but paroxysmal auricular fibrillation and paroxysmal auricular flutter and paroxysmal ventricular tachycardia have been reported. During episodes of supraventricular paroxysmal arrhythmias the QRS has been found to be of normal duration except in a case recently reported by Movitt,[19] in which the prolongation of the QRS persisted. 5. The preponderant number of cases so far reported have not been associated with organic heart disease, and when heart disease is present it is a coincidental finding. Cases have been reported by Palatucci and Knighton[6] and by Eichert[9] in which there are spontaneous alterations in the T waves which must be differentiated from coronary artery occlusion. A similar problem arises in case 1 of the present series in which during normal rhythm the electrocardiogram had the appearance of a healing anterior myocardial infarction and several months later the complexes with normal conduction have the appearance of a healed posterior myocardial infarction.

There is an increased incidence in the male sex over the female, and thus far the greater number of cases have been reported in persons under 30, but the number is increasing in the older age groups.

Wolferth and Wood[13] and Holzman and Scherf independently proposed the theory that there is an accessory conduction bundle between the right auricle and one of either of the ventricles. If the aberrant pathway extended from the right auricle directly to the right ventricular musculature, a portion of the latter would become prematurely excited in such a way that the onset of the QRS complex is earlier than if conduction were by the normal His bundle and right bundle branch. The left ventricle in this instance receives its stimulus via the normal conduction pathway and at the normal time. It is probable that the right ventricle may also receive a portion of its stimulus through the right bundle branch. The net result, if the excitation wave arises normally in the sino-auricular node, is that the P wave is normal but the PR interval is shortened due to the premature excitation of the right ventricle; the onset of the QRS is slurred since the excitation wave travels through the myocardial fibers in a wave front fashion and does not reach all parts of the right ventricular musculature at approximately the same time through the Purkinje system. Since conduction through myocardial fibers is slower, the initial rise of the onset of the QRS complex is slower and more gradual than normal. In this instance the QRS complex in lead I resembles that seen in left bundle-branch block, since there is a "relative" delay in excitation of the left ventricle. Conversely, if the aberrant conduction pathway passes from the right auricle to the left ventricle, the QRS complex resembles that seen in right bundle-branch block with the difference that the PR interval is shortened and the main part of the slurring of the complex occurs in its left ventricular component.

The abnormality is present when impulses pass both through normal and abnormal conduction pathways and is absent when the abnormal pathway fails to conduct or conducts in retrograde fashion. The former explains the reversion to normal complexes during normal sinus rhythm.

Anatomic support for the theory was found in the studies by Kent,[26] who demonstrated muscular bundles bridging the auriculoventricular groove from right auricle to right ventricle. Wood, Wolferth and Geckeler[15] studied histologically the heart of a patient who died during a paroxysm of tachycardia and found 3 muscular bridges connecting the right auricle and right ventricle. Glomset and Glomset[27] have found similar muscular pathways in otherwise clinically and pathologically normal hearts. The mere presence of these pathways, therefore, does not ipso facto lead to the conclusion that they are capable of conducting impulses.

However, Wolferth and Wood feel that this theory fully explains all the varied phenomena found in this syndrome. Besides explaining the short PR interval and the prolonged QRS complex and periods of normal conduction, supraventricular tachycardia is explained by reëntry into the auricle by reverse conduction over the accessory pathway and restimulation of the ventricles over the normal pathway, thus creating a circus movement: ventricles → reverse conduction over accessory bundle → auricle → normal conduction pathway → ventricles. Ventricular tachycardia is probably explained by reverse conduction into the auricle by one accessory bundle and reëntry into the ventricle by way of another accessory bundle.

Physiologic support to the theory has been given by the experiments of Butterworth[16] and Butterworth and Poindexter,[10,28] who by using a special type of amplifier picked up action currents from the right auricle and passed them directly to the right ventricle. As soon as the amplifier was turned on the PR interval became shortened and the QRS complex became prolonged. The contour of the QRS complexes resembled that of left bundle-branch block. When the connection was made from the right auricle to the left ventricle the QRS complex then resembled right bundle-branch block. As soon as the amplifier was turned off normal rhythm was again restored. All gradations could be produced by varying the timing of transmission of the impulse through the amplifier. By reversing the passage of impulses through the amplifier, action currents from the ventricle were passed to the auricle, and supraventricular tachycardia was immediately produced.

Rosenbaum et al,[11] after extensive studies of 10 cases, using unipolar precordial and esophageal leads, conclude that the hypothesis of accessory pathway must be true according to our present knowledge of the conduction system and must be due to an accessory pathway not necessarily far removed from the normal conduction pathway or to "some peculiarity of the atrioventricular node, bundle or bundle branches."

Attempts have been made to further the knowledge of this syndrome by using vagal stimulation, vagus release, and sympathetic stimulation either mechanically or pharmacologically, by direct action of digitalis on the conduction system, and by quinidine. The results obtained by these methods offer some apparent contradictions. Thus vagal stimulation by carotid sinus pressure produced no change except slowing of the heart rate in cases observed by Roberts and Abramson,[29] Fox, Travell and Molofsky,[21] and Pearson and Wallace;[8] while normal PR intervals and QRS complexes were restored in those reported by Wedd,[3] Sigler,[30] and normal QRS complexes with A-V nodal rhythm in case 1 of the present series. Vagus release by atropine had no effect in cases studied by Roberts and Abramson,[29] Bishop,[31] Butterworth and Poindexter,[28] and Pearson and Wallace,[8] while Fox et al[21] and case 1 of the present series showed, in addition to the increase in speed, shortening of the QRS complexes and abolition of the slur on the upstroke of the QRS. Wilson,[2] Wolff, Parkinson and White,[1] Tung,[32] and Palatucci and Knighton[6] were able to restore the QRS complex to normal.

Sympathetic stimulation by means of exercise produced no change in the abnormal complexes according to Roberts and Abramson, Fox et al, and Pearson and Wallace, but restored normal conduction in cases reported by Wolff et al, by Bishop and in case 1 of the present series.

Quinidine in adequate amount restored normal conduction in most cases published in which it was used, including the present case 1.[8, 13, 14, 20, 23, 29]

Digitalis caused first a prolongation of the QRS complexes in a case of Scherf and Schonbrunner (quoted by Fox and Bobb), and as digitalization was continued reversion to normal complexes occurred. Fox et al[21] found that digitalization invariably produced widening of the QRS complex. Fox and Bobb[23] in another report were unable to cause further widening of the QRS complex during the time abnormal conduction was present, but when the QRS complex was of normal duration intravenous digitalization almost immediately produced reappearance of short PR intervals and prolonged QRS complexes. Fox[33] describes a case of short PR interval and abnormal but not prolonged QRS complex in which digitalis produced widening of the QRS complex without effect on the PR interval. Case 1 of the present series was restored to normal conduction after digitalization. No effect on the aberrant conduction was produced by digitalis in cases studied by other authors.

These apparent inconsistencies can be resolved by consideration of the relative effect of stimuli or direct action of drugs on one or the other conduction mechanism. Stimulation of the right vagus by means of carotid sinus pressure normally causes sino-auricular slowing or even sinus arrest by inhibition of the irritability of the node. If this effect spread to the aberrant conduction tissue so that its conductivity were reduced, any impulse originating in the sinus node would pass down the normal conduction route and result in PR intervals and QRS complexes of normal duration. During periods of sinus standstill A-V nodal rhythm may appear, and during this period QRS complexes of normal duration will occur since all stimuli pass through the His bundle and have no access to the aberrant pathway. Since the effect of vagal stimulation by this method varies greatly in normal individuals, it is natural to expect that the above effects would be absent in many cases of the syndrome under discussion. Left carotid sinus pressure produces left vagal inhibition which causes mainly interference of impulses from the auricular musculature to the A-V node and decrease in irritability of that node. Presumably greater influence could be exerted on the abnormal pathway with a result similar to that produced by right carotid sinus pressure.

Atropine normally may have one of two effects on the heart, depending on whether right or left vagal effect predominates. Thus, if right vagal release is greater, there is an increase in the heart rate due to increase in the impulse initiation by the sinus node; if the influence of the left vagus is removed more than that of the right, the A-V node may become more irritable than the sinus node and thus initiate impulses at a greater rate than the latter, in which instance A-V nodal rhythm is produced. Thus, in the syndrome under discussion, predominantly right vagus release will increase the speed of the sinus impulses without affecting the duration of the QRS complex, while the same situation applying in the left vagus may produce A-V nodal rhythm. In the latter instance the duration of the QRS complex would be normal, since impulses pass only through the normal pathway.

Sympathetic stimulation by means of exercise may or may not cause impulse initiation to occur at such a rapid rate that the accessory pathway is unable to receive them. Sympathetic stimulation increases both the irritability and conductivity of the sinus and A-V nodes.

Quinidine, which is a general protoplasmic poison, probably produces more depression of conductivity and irritability in the accessory bundle than in the normal conduction mechanism and thereby restores the electrocardiogram to the normal conduction pattern.

The paradoxical action of digitalis has been explained by its predominant depression either on the normal conduction pathway, in which case it would cause an increase in the QRS duration, or predominant depression of the abnormal pathway, in which case the QRS time would be decreased. In those instances in which the QRS complex becomes prolonged it is presumed that the accessory pathway is not functioning to its greatest capability. The mild depression of digitalis in therapeutic dosage on the normal conducting mechanism allows the excitation wave traveling over the accessory bundle to reach more of the ventricle ahead of the normally conducted impulse.

REPORT OF CASES

Case 1. C. E. G., a white male, aged 49 years, was first seen in consultation March 10, 1945 at the request of another physician to evaluate his cardiac status following coronary artery thrombosis. He had been perfectly well until the early morning hours of May 7, 1944, when while working at his regular occupation as a monotypist his left arm began to feel very tired. He shook it a few times and it felt a little better, but shortly after there was recurrence of the tired feeling. He again shook and rubbed the arm and it felt better in a few minutes. During the next 4 hours there were repeated recurrences of this experience, but he was able, with some difficulty, to finish his work at the customary hour of 6 a.m. At this time the sensation of "tiredness and numbness" had become constant, and, although he could move the arm at will, it had the feeling of being dead. He drove his car home, a distance of about 5 miles, using only his right hand. There was no dyspnea or tightness in the chest during this period.

At 7 a.m. on the same date he suddenly developed agonizing "sharp" pain in the left upper precordium which radiated down the medial side of the left arm to the elbow. At the same time there was numbness in the ulnar side of the forearm down to the hand. He was unable to lie or to sit down and was forced to pace the floor, walking from one room to another and up and down stairs many times. The pain came and went in a wave-like manner but never entirely disappeared at any time. He did not feel as if he could not get his breath but stated he gasped frequently due to the intensity of the pain. There was no sensation of substernal pressure. A physician was called, and after taking his blood pressure and listening to the heart gave him a "hypo." The medication had very little effect, but the patient stated that he was "able to relax just a little." Another physician, called by the first, took an electrocardiogram about 6 hours after the onset and while pain was still present. This record is not available, but this physician stated that the limb leads were within normal limits while lead IVF showed an inverted T wave.

Both physicians described the patient as being extremely restless, sweating profusely and quite weak. He did not appear dyspneic. The blood pressure at the time of the attack was 110/60. Heart and pulse rates were 100 to 110 per minute. The heart sounds were distant and a few moist râles were discernible at the right base.

Following the acute episode, which lasted in all about 8 hours, the patient's left arm felt numb for about a week. He was kept in bed for a period of 3 months. There is no record of his temperature, pulse, leukocyte count or sedimentation rate during the entire period. He has been allowed up gradually, and with the exception of occasional numbness, unrelated to exertion, excitement or meals, he feels pretty well.

At the first interview he stated he had been able to walk around, drive his car and do simple things around the house. He was dreadfully afraid of going back to work for fear of a recurrence of the pain. From time to time he felt quite ambitionless and "all washed out," but these symptoms were entirely unrelated to any sensation in the arm or over the precordium.

Careful questioning failed to elicit any symptoms remotely resembling angina pectoris or episodes of tachycardia prior to the present illness. On one occasion, several years before, he was told by a physician that his blood pressure was a little high but that it was not within a dangerous level. Since he had been up and around he had noted slight dyspnea on exertion, especially going upstairs, and was easily tired. Occasionally at night he could feel his heart beating but this was more forceful than rapid.

The past history and family history were irrelevant.

Physical examination revealed him to be stocky, well developed and well nourished. The blood pressure was 150/100. The pulse was 86 per minute and regular. Respirations were 16 per minute and the temperature 98° F. He weighed 163 lbs. and his height was $67\frac{1}{2}$ inches.

The optic fundi showed increased tortuosity of the arterioles, increase in brilliance of the light reflex, and early arteriovenous compression. The head and neck were otherwise normal.

There were no obvious external abnormalities of the chest. The heart exhibited normal pulsations and the P.M.I. was in the 5th intercostal space 8.5 cm. from the midsternal line. The sounds were of good quality, and the aortic and pulmonic second sounds were of equal intensity. There were no murmurs. The lungs were clear.

The rest of the physical examination revealed no abnormalities.

A hemogram on March 1 showed the erythrocytes to number 4,650,000, with hemoglobin of 14 Gm. The leukocytes numbered 7,200, and the differential count showed 72 per cent polymorphonuclears, 23 per cent lymphocytes, 1 per cent eosinophiles, and 3 per cent monocytes. A urinalysis revealed a specific gravity of 1.026, no albumin, no reduction of Benedict's reagent and 0 to 1 hyaline casts per high power field. The erythrocyte sedimentation rate (Cutler) was 8 mm. per hour on the same date. The Kahn (3/8/45) was negative. A teleoroentgenogram revealed the lung fields to be clear except for a small calcification 0.5 mm. in diameter located in the peripheral portion of the left upper lobe. The transverse diameter of the heart measured 14 cm., and the greatest internal diameter of the chest was 30 cm. The left ventricle presented a greater convexity of the left curve than normal and there was slight dynamic dilatation of the aorta.

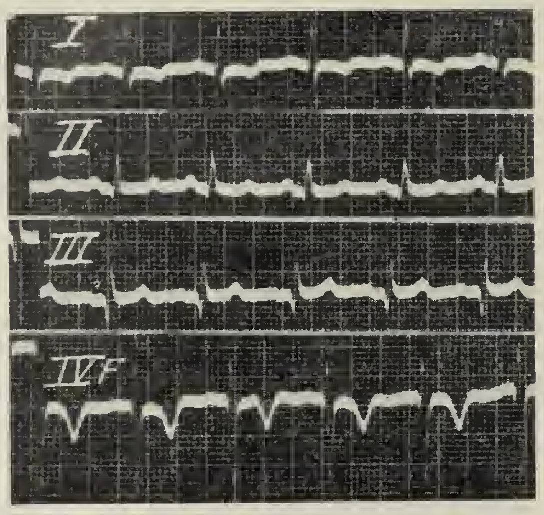

Fig. 1. Case 1. July 7, 1944, 51 days after onset of symptoms; PR interval = 0.15 sec.; QRS duration = 0.07 sec.; auricular and ventricular rates 95 per minute.

The depressed upwardly convex ST_1 ending in a sharply inverted T_1 together with slight elevation of ST_3 and depressed upwardly convex ST_{4F} ending in a deep inverted and pointed T_4 have appearance of somewhat atypical anterior myocardial infarction in healing or T-stage. S_1, Q_2, and Q_3 present; R_4 present.

The electrocardiogram of July 7, 1944, 2 months after the acute episode, shows auricular and ventricular rates averaging 95 per minute (fig. 1). The rhythm is regular and of sinus origin. The P waves are upright and of normal contour in all leads. Auriculoventricular condition time (PR) measures 0.15 second. All QRS complexes are slightly slurred, and the QRS interval is 0.08 second. There are small Q waves in leads I and II and Q_3 is greater than 25 per cent of the total height of the QRS_3. ST_1 is slightly depressed and has an upwardly directed convexity; ST_3 shows slight elevation and is concave upward; ST_2 is isoelectric; ST_4 is slightly depressed and coved. T_4 is inverted; T_2 and T_3 are upright and pointed; T_4 is sharply inverted and pointed. These changes are consistent with the healing stage of a some-

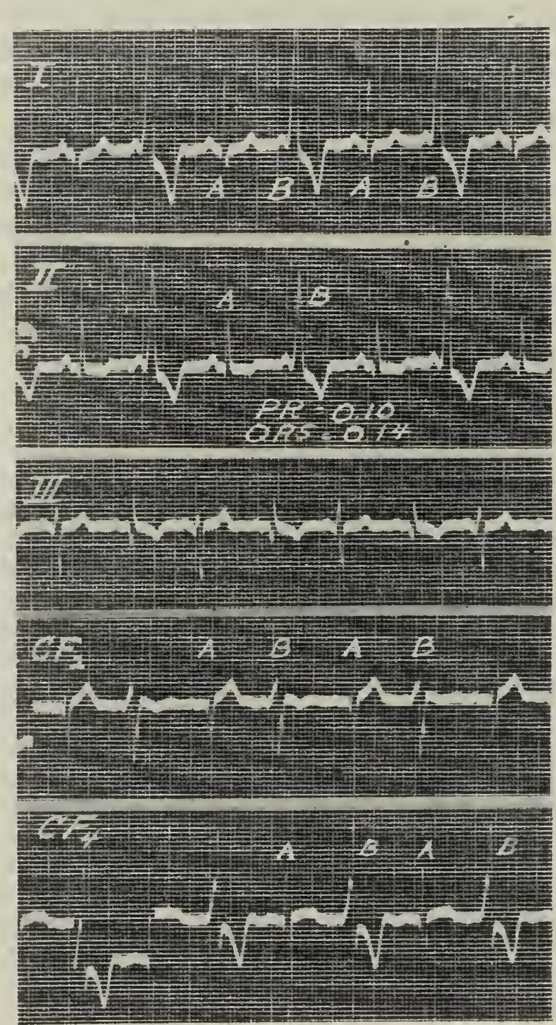

Fig. 2. Case 1. March 1, 1945, about 9 months after onset of symptoms; PR and QRS complexes of normal duration alternating with complexes of short PR interval and prolonged QRS complexes (see text).

what atypical anterior myocardial infarction or with left ventricular strain.

On his first interview the patient brought with him an electrocardiogram taken elsewhere, February 28, 1945. This had been reported as showing premature ventricular beats and evidence of an old healed myocardial infarction. On March 1, 1945 the same configuration was present (fig. 2). There is an auricular and ventricular rate of 86 per minute and the rhythm is of sinus origin with slight sinus irregularity. There is a remarkable alternation of PR intervals and QRS shape, size and duration with every other beat. The complexes, A, have a PR interval of 0.16 second and a QRS of 0.6 second on the average, while the complexes, B, show a PR interval of 0.10 second and a QRS complex of 0.12 second. In both instances the PS interval (from the onset of P to the end of the QRS) is the same, viz., 0.22 second. Thus the widening of the QRS in the complexes, B, is at the expense of the PR interval.

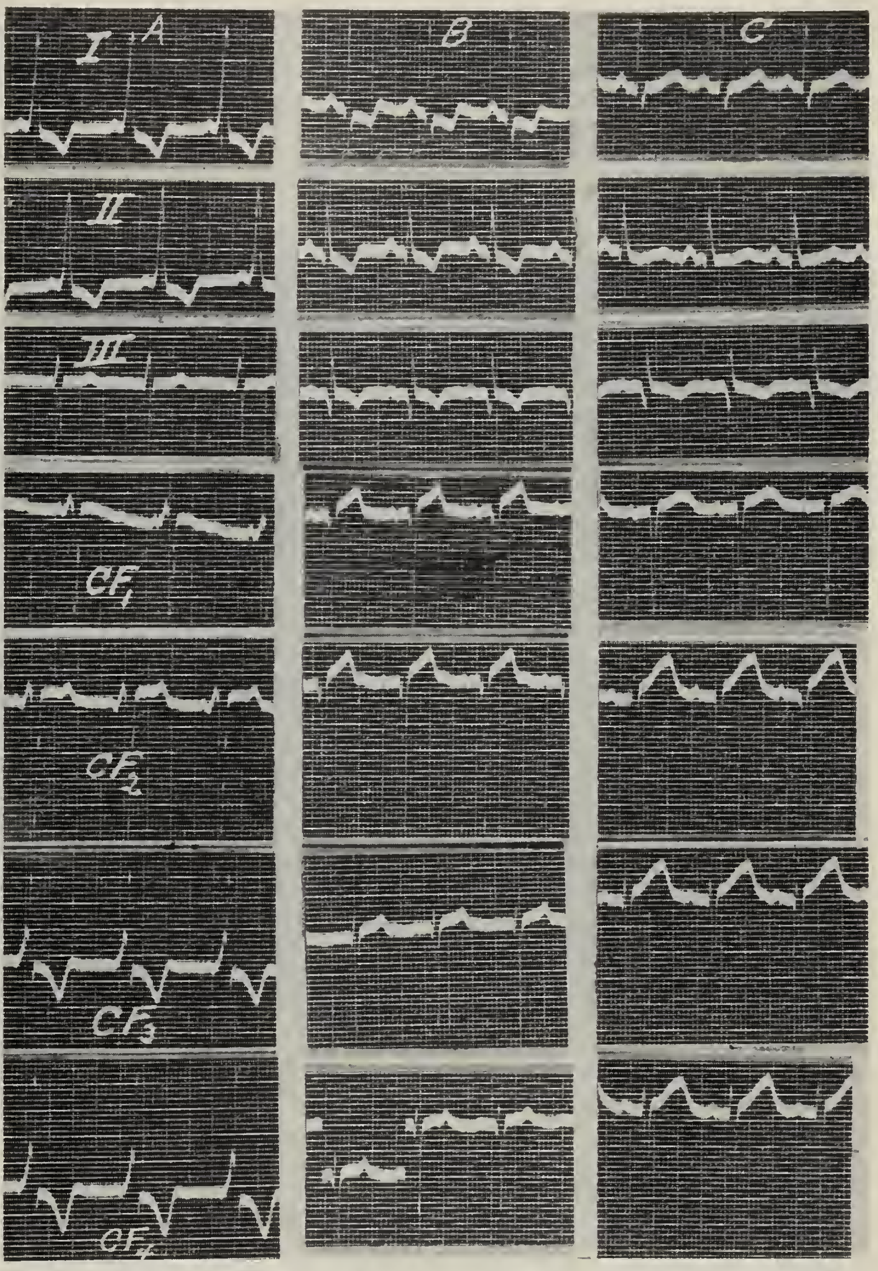

FIG. 3. Case 1. A. March 23, 1945. Short PR intervals and prolonged QRS complexes throughout. PR = 0.12 sec.; QRS = 0.12 sec.; PS duration = 0.24 sec.

B. After full digitalization (see text). PR and QRS of normal duration; digitalis effect; PR = 0.16 sec.; QRS = 0.08 sec.; PS duration = 0.24 sec.

C. After quinidine (see text). PR = 0.16 sec.; QRS = 0.08 sec.; PS duration = 0.24 sec. ST-T combinations prolonged and T waves rounded, as commonly seen after quinidine.

There are other important differences between these two sets of complexes. In the A complexes the voltage is approximately one half that of the B complexes. In the A group ST_1 is isoelectric and is followed by an upright T wave. ST_2 is isoelectric and is followed by a diphasic T. ST_3 is bowed upward and is followed by a deep, pointed T. Q_3 is deep. The ST-T combinations in this group have the appearance of a healed posterior myocardial infarction. In the precordial leads, CF_2 and CF_4, alternation occurs but there is no further information to be gained from them.

In the B group, in the limb leads ST_1 and ST_2 are depressed, upwardly bowed and followed by deeply inverted T waves. There is a deep S_3 and T_3 is upright.

Moderate exercise caused an increase in rate from 90 to 110 per minute. In the A group of complexes Q_3 became smaller and the depth of T_3 increased. In the B group the PR interval became 0.11 and the QRS 0.11 second. ST_1 and ST_2 were more depressed and T_1 and T_2 deeper.

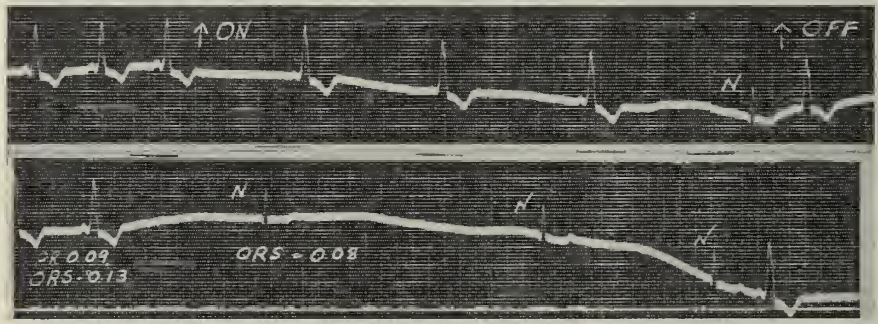

Fig. 4. Case 1. Effect of carotid sinus pressure. A—Left carotid sinus pressure. B—Right carotid sinus pressure. N—Nodal escape beats.

During the following 4 months over 50 electrocardiograms were taken and the experiments described below were repeated at least 3 times each. On March 7, 1945, the electrocardiogram showed all complexes to have a short PR interval with a prolonged QRS complex (fig. 3, A). The average heart rate varied between 80 and 85 per minute. PR intervals ranged from 0.10 to 0.12, while the QRS complexes varied from 0.12 to 0.14. The shorter PR intervals are associated with the longer QRS complexes in such a way that the PS interval is constant throughout at 0.22 second. These complexes in every respect resemble the B complexes of fig. 2. It may be noted that there is respiratory variation in the height of R_1 reciprocal with S_3. All QRS complexes are huge and have a prominent slur on the upstroke which stops abruptly about ⅓ the distance to the peak. The peak of the R wave is not midway between onset and offset of the QRS deflection but is reached after the QRS has reached ⅔ of its duration; thus the upstroke is slow and gradual as compared to the rapid decline of the downstroke. Onset to peak varies from 0.6 to 0.8 second as compared with peak to offset, which varies from 0.4 to 0.6 second. The shorter time measurements are associated with the shorter total QRS durations and vice versa. There is depression of ST_1, ST_2, and CF_4, with upward convexity of these segments, and the T waves following them are inverted.

On March 23, 1945 all complexes were again of the aberrant type, and the heart rate was 88 per minute (fig. 3B). The effect of carotid sinus pressure (lead II) was tried, and the result is shown in figure 4. The strip labeled A illustrates the effect of left carotid sinus pressure. There is gradual slowing of the sinus node with diminution of the size of the P wave and decrease in the PR interval. The QRS complexes become more and more grossly slurred and increased in width. Following the third beat after pressure was applied, the A-V node escapes with the production of A-V nodal rhythm, and the QRS configuration and duration become exactly the same as those previously described as resulting from normal conduction and originating in the sinus node. Upon application of pressure to the right carotid sinus sino-auricular block is immediately produced and endures for 7.68 seconds (fig. 4 B). During this period 3 middle nodal escape beats are produced. A control electrocardiogram following this showed all beats to be of the abnormal variety.

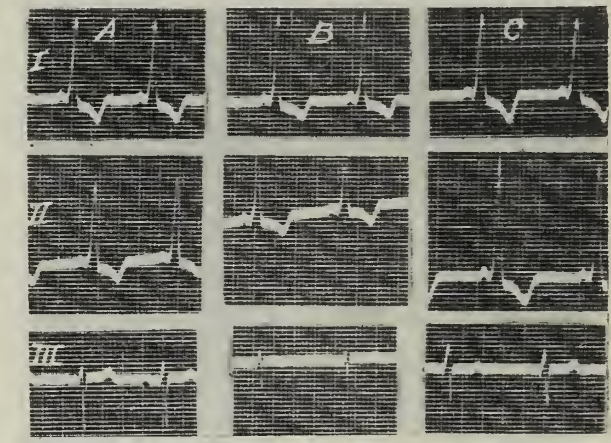

Fig. 5. Case 1. A—Control; B—After atropine; C—After prostigmine.

Quinidine sulfate was then administered orally, 0.4 Gm. (6 grains) every 2 hours for 4 doses, following which the PR intervals and QRS durations become normal (fig. 3C). The PR interval measures 0.16 second and the QRS complex 0.09 second. The rate is 100 per minute. There is notching of the P waves in leads I and II, and all T waves are more rounded. The ST-T segments are prolonged from 0.32 second (as in the normal beats of previous electrocardiograms) to 0.36 second.

A control electrocardiogram, March 25, 1945, revealed all complexes to have returned to the aberrant form (fig. 5A). Prostigmine methyl sulfate (1:2000 solution), 2 c.c., was given intramuscularly and 15 minutes later 1 c.c. was repeated. One half hour following the first injection the QRS complex measured 0.14 second, and both limbs became more convex outward (fig. 5C). No side reactions were noted except slight increase in intestinal peristalsis. One hour was allowed to elapse, at which time the electrocardiogram was the same as at the beginning of the experiment. Atropine sulfate, 0.9 mg. (1/75 gram) was then administered intravenously, and immediately thereafter the QRS complex narrowed to 0.09 and 0.10 second without change in the PR interval (fig. 5B). The ST segments were less depressed, and the T waves in leads I and II were less deeply inverted. The T wave in lead III became low to flat. These changes were less marked after 15 and 30 minutes. These experiments appear to indicate that prostigmine caused a slight change away from normal and atropine toward normal.

The patient was then fully digitalized, whole leaf being used, with a total of 18 cat units in 3 days, and another electrocardiogram was taken (fig. 3B). The heart rate is 100 per minute. The PR interval measures 0.16 second and the QRS complex 0.07 second. Digitalis effect is readily apparent in the ST-T segments of leads I and II. Right carotid sinus pressure (fig. 6—1) promptly produced sinus arrest, during which period the A-V node became the pacemaker at a rate of about 45 per minute. There is shifting of the pacemaker within the A-V node: Beats N-1, N-5 and N-6 are lower nodal, while beats N-2, N-3 probably arise in the middle of the A-V node. The S wave of the nodal beats is deeper, and the terminal upward deflection of the diphasic T wave is much higher than in the beats of sino-auricular origin.

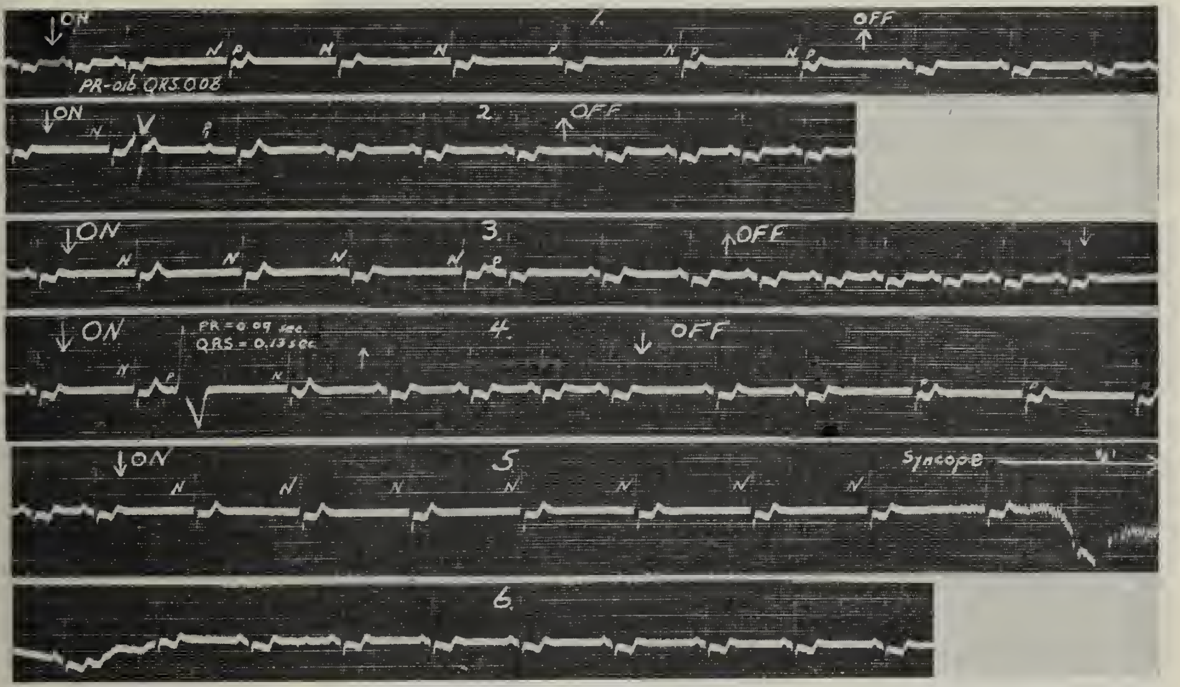

FIG. 6. Effect of carotid sinus pressure after full digitalization: (1) right carotid sinus pressure with production of noda escape beats; (2) left carotid sinus pressure (a ventricular premature contraction is present third beat from the left; nodal escape beats present); (3) left carotid sinus pressure; (4) right carotid sinus pressure (the fourth beat from the left resembles short PR and prolonged QRS); (5) bilateral carotid sinus pressure; (6) 2 minutes after bilateral carotid sinus pressure.

After a rest period of 10 minutes, pressure was applied to the left carotid sinus (fig. 6—2). A nodal escape beat occurs shortly after and is immediately followed by a ventricular extrasystolic beat. A P wave follows, but it is doubtful if it initiates the next ventricular systole, since this more closely resembles those of nodal origin rather than of sinus origin. Sinus rhythm then follows. Application of pressure to the left carotid sinus again caused the production of nodal rhythm as before, but the sinus regained control before the pressure was released (fig. 6—2). A rest period of 10 minutes was again allowed.

Right carotid sinus pressure was again applied (fig. 6—3). A nodal escape beat appears and is followed by a complex with a short PR interval and a prolonged QRS complex (PR, 0.09 sec. and QRS, 0.13 sec.); then another nodal beat followed by sinus rhythm for 6 beats and subsequently lower nodal rhythm. This was the only time that a beat showing aberrant conduction appeared during the time the patient was digitalized.

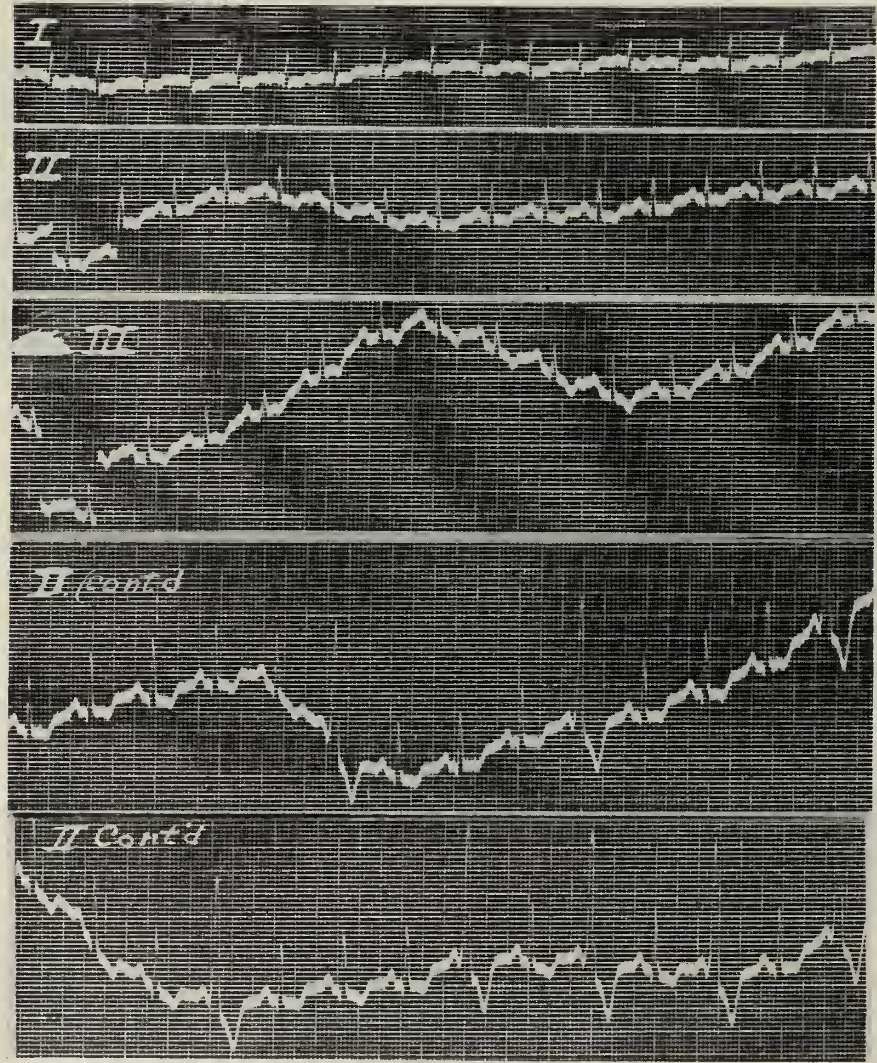

FIG. 7. Case 1. Immediately after violent exercise. Strips 4 and 5 show transition back to alternating complexes.

Comparing the effects of carotid sinus pressure before and after digitalization, it would appear, in this case, that the sinus node is more susceptible to vagus stimulation during right and left carotid sinus stimulation after digitalization than before. However, the A-V node is more irritable, since the rate of passive nodal rhythm is much greater after digitalization than before. Before digitalization both right and left carotid sinus stimulation caused increase in the width of the QRS complex, outward bowing of both limbs of the complex, and increased slurring. These features disappear as soon as A-V nodal rhythm appears and are not present in the aberrant complexes following release of the pressure.

As to the 4th beat from the left in strip 4, where a small P wave with a short PR interval (0.09 sec.) is followed by a widened slurred QRS complex (0.13 sec.), it is not clear whether it originates in the same manner as the other aberrant complexes in this syndrome or is an auriculo-ventricular fusion beat or merely a ventricular extra systole with the P wave appearing in front of it fortuitously.

Fig. 6—5 illustrates the effect of bilateral carotid sinus pressure. Nodal rhythm is produced, and toward the end of the strip the patient had syncope and a mild clonic convulsion. Strip 6 was taken immediately after the convulsion. The syncope was not due to carotid slowing, since the rate is about 48 per minute.

On May 15, 1945, 4 weeks after the last dose of digitalis, a control electrocardiogram showed aberrant complexes alternating with normal ones as on the first observation. The patient was instructed to run in place and exercise as violently as possible to the point of fatigue. In 4½ minutes he had moderately severe dyspnea and sharp precordial pain radiating down the medial side of the left arm to the wrist. He lay down immediately, and an electrocardiogram was taken (fig. 7). This shows a rapid sinus rhythm (148 in lead I, 130 in lead II, and 120 in lead III), with normal duration of the QRS complexes (0.06 sec.). There is borderline low voltage. ST segments are depressed in all 3 limb leads. T_1 is diphasic, whereas T_2 and T_3 are inverted. Following through lead II shows gradual restoration of the alternating type of rhythm. Since the control electrocardiogram showed T_1 upright, T_2 diphasic, and T_3 less inverted than during the bout of tachycardia, it is evident that the ST-T configuration present during this tachycardia induced by exercise is due to coronary insufficiency and therefore that coronary arteriosclerosis is probably present. This is in keeping with the original electrocardiogram. It must be admitted, however, that a prolonged episode of paroxysmal tachycardia to which these patients are subjected could produce T wave changes similar to those found in figure 1 as well as the symptoms which he had at the time. It is therefore a nicety of judgment in dealing with patients with this syndrome in this age group to determine whether some of them who have symptoms of prolonged anginal pain may not have coronary insufficiency on the basis of the tachycardia or acute coronary insufficiency due to coronary artery disease. Electrocardiograms taken after a bout of tachycardia may be quite confusing.

This patient has remained in relatively good health since his last visit, June 12, 1945 and has not had any symptoms save those of mild anxiety.

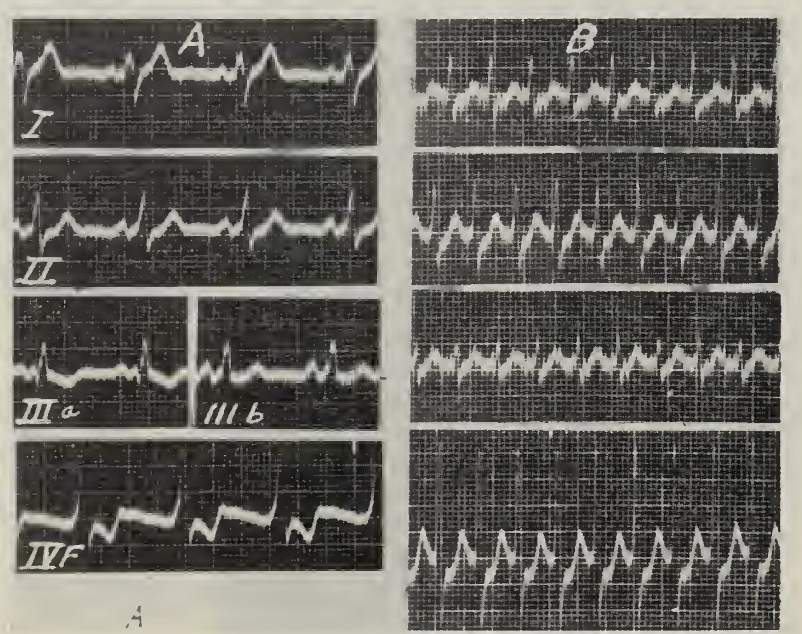

Fig. 8. Case 2. Before therapy. A. Sinus rhythm; III-a, quiet respiration; III-b, deep inspiration; B. During paroxysms of supraventricular tachycardia.

Case 2. B. J., a white Jewish male 30 years of age, was first seen October 2, 1944 by another physician. At that time his chief complaint was episodes of rapid beating of the heart of sudden onset and offset accompanied by giddiness and faintness and a feeling as if he were going to fall. He had lost consciousness only on one occasion but had had blackness before the eyes on many occasions. The attacks were first noted at the age of 8 years, occurring 8 times during a period of 3 or 4 months and then entirely disappearing for the following 20 years. In the spring of 1942 he began to have episodes every 3 or 4 months which gradually increased in frequency, until during the 6 months prior to consultation they had been occurring almost daily and as many as 3 on a single day. If a day or so were skipped it appeared that the attacks were more frequent on the following days. The average duration of an attack was about 30 minutes. One month previous, another physician had prescribed quinidine sulfate, 0.2 Gm. (3 grains), 2 to 3 times a day, and, although this drug did not seem to diminish the frequency of attacks to a marked degree, it shortened their duration to about 1 to 5 minutes.

Physical examination revealed the patient to be moderately obese. The blood pressure was 120/80 and the pulse rate 80 per minute. There were no abnormal findings on physical examination.

Prior to any therapy, May 18, 1944 an electrocardiogram was taken (fig. 8A). This shows sinus rhythm with auricular and ventricular rates of 70 per minute. The P waves are upright in the limb leads and diphasic in IVF. The PR interval is 0.12 second and the QRS complex 0.14 second. It is noted that what at first glance appears to be the isoelectric interval beginning immediately after P and ending with the onset of the QRS complex is in fact not isoelectric at all but has an upward inclination in all 3 limb leads. This is most readily discernible in lead II and after deep inspiration in lead III (b). In lead III during quiet respiration the P wave is followed by an upward wave which is a positive component of a polyphasic QRS complex. Moreover, there is notching and slurring in the upward component of the QRS in each of the limb leads. S_1 is deep, and S_2 is present. The ST segments in the limb leads are isoelectric, and the T waves are upright. This is the configuration of the electrocardiogram of the syndrome under discussion, but, in contrast to case 1, the configuration of the QRS complex is that of right bundle-branch block whereas that of the former is left bundle-branch block.

Just at the time the patient was about to leave, he began to experience an attack of rapid beating of the heart, and immediately another electrocardiogram was taken (fig. 8B). Supraventricular tachycardia is present at a rate of 196 per minute. The QRS complex duration is normal (0.08 sec.). ST_1, ST_2, ST_3 and ST_4 are depressed. The rhythm is not absolutely regular, but alternation of the cycle length as described by Barker et al[34] is present. The P waves can be identified about 50 per cent of the time, just beyond the crest of the preceding T wave in leads II and III. This paroxysm subsided spontaneously.

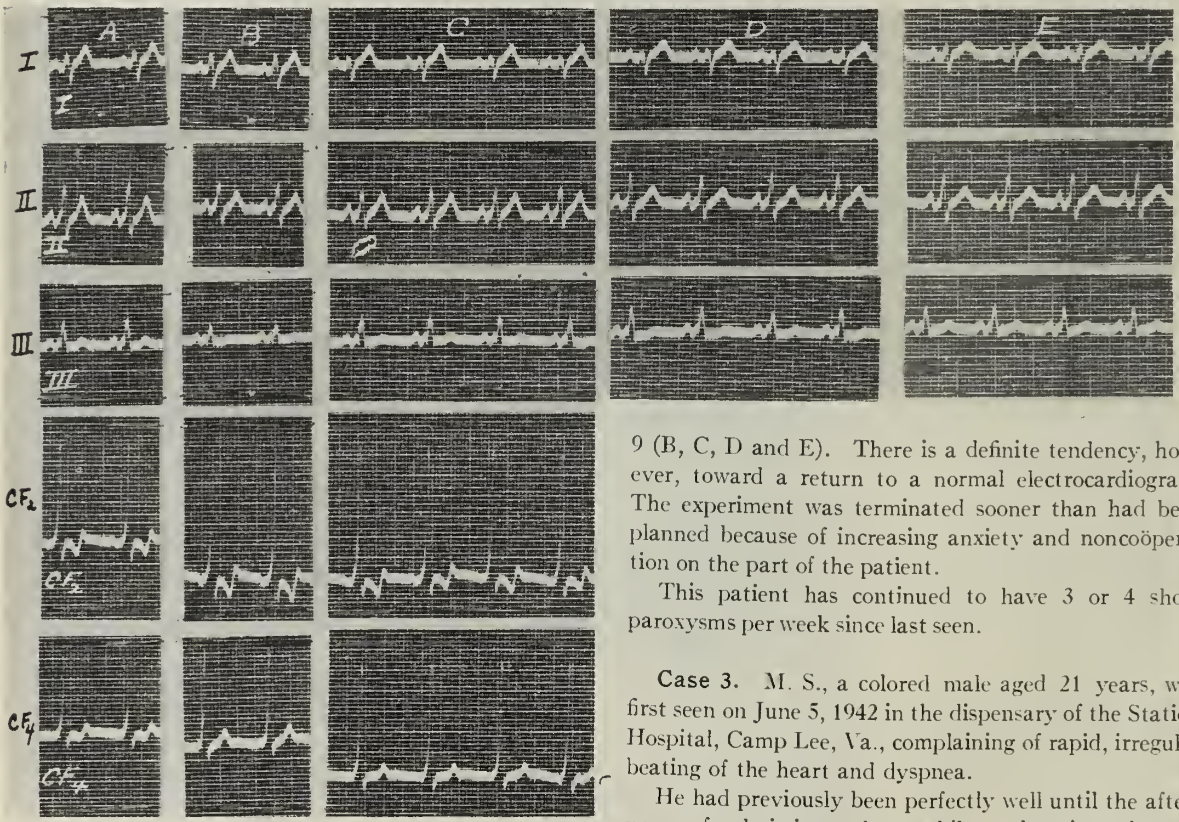

Fig. 9. Case 2. (See text.)

For 48 hours before the rest of the electrocardiograms in this case were taken (May 20, 1945) quinidine was omitted for 48 hours. The electrocardiogram of figure 9A resembles the previous one. Tracings were taken in recumbency, sitting, and standing, after vigorous exercise, and during the Valsalva experiment. None of these procedures produced any significant change in the electrocardiogram save that of increasing the heart rate. There was slight depression of ST_1 and ST_2 as increasing intensity of exercise was undertaken.

Various attempts were made to induce an attack of tachycardia without success. This patient had a rather severe anxiety state which precluded reduplication of the experiments which were done in the previous patient. He was persuaded, however, to take quinidine sulfate, 0.4 Gm. (6 grains), and an electrocardiogram was taken every half hour for 2 hours. This series is shown in figure 9 (B, C, D and E). There is a definite tendency, however, toward a return to a normal electrocardiogram. The experiment was terminated sooner than had been planned because of increasing anxiety and noncoöperation on the part of the patient.

This patient has continued to have 3 or 4 short paroxysms per week since last seen.

Case 3. M. S., a colored male aged 21 years, was first seen on June 5, 1942 in the dispensary of the Station Hospital, Camp Lee, Va., complaining of rapid, irregular beating of the heart and dyspnea.

He had previously been perfectly well until the afternoon of admission, when, while undergoing vigorous exercise, he suddenly became moderately dyspneic and felt his heart beating rapidly and irregularly. Alarmed, he immediately sought medical aid.

His past history was noncontributory and he had not experienced any such episodes previously.

Physical examination showed him to be well developed and nourished. The blood pressure was 116/80, and the pulse rate 120 per minute and totally irregular. The heart beat was totally irregular at a rate of 144 per minute. The heart tones varied in intensity but no murmurs or other abnormalities were noted. The rest of the physical examination was normal.

He was put to bed and given sedation. On the following morning an electrocardiogram was taken (fig. 10A) which disclosed a regular sinus rhythm with auricular and ventricular rates averaging 78 per minute. The P waves were not discernible in lead I but were upright in leads II and III and inverted in IVF. The PR interval measured 0.10 second. The huge, bizarre QRS complexes had a pronounced slur on the upstroke of R and measured 0.12 second in duration. ST_1 and ST_2 were depressed; ST_3 and ST_4 were isoelectric. T_1 was diphasic, but the T waves in other leads were upright.

Quinidine sulfate, 0.4 Gm. (6 grains), every 2 hours for 5 doses had no effect, nor did digitalization nor atropinization affect the electrocardiogram.

No abnormalities were noted in the blood, Kahn, urine, sedimentation rate or teleoroentgenogram.

During a 2 months' period of observation there were no changes in the electrocardiogram, nor did the patient experience any further paroxysms of fibrillation.

Case 4. R. P., a white male 57 years of age, was admitted to the Arlington Hospital, September 9, 1944, because of cirrhosis of the liver, decompensated with jaundice. An accurate history was not obtainable. An electrocardiogram was taken on September 29, 1944, and the patient died shortly afterwards. A postmortem examination was not obtained.

The electrocardiogram (fig. 10B) shows auricular and ventricular rates of 100 per minute. In lead I the PR interval measures 0.15 second and the duration of the QRS complex is 0.06 second. In leads II and III there is a marked change; and the PR interval has become 0.12 second and the abnormal-shaped QRS complex, 0.12 second. In other words, there has been a change from normal conduction in lead I to abnormal conduction of the Wolff-Parkinson-White type in the rest of the leads.

Discussion

These 4 cases are typical of the syndrome originally described as a clinical entity by Wolff, Parkinson and White. It has long ago been universally agreed upon that it is unwise and confusing to name clinical entities or diseases by proper names. The name describing the electrocardiographic picture, viz., short PR interval and prolonged QRS complex, is very graphic but is purely descriptive. Although all evidence points toward the existence of an accessory conduction bundle in the production of the syndrome, this has not been proven beyond the shadow of a doubt. It has been proposed that the syndrome be named premature ventricular excitation, since this has been shown to be the case and is more fundamental in its description, one or the other ventricle being excited before the other.

Of the 4 cases 3 of them (cases 1, 3 and 4) showed ventricular complexes resembling left bundle-branch block, which means that the right ventricle is excited before the left. The converse is true regarding case 2.

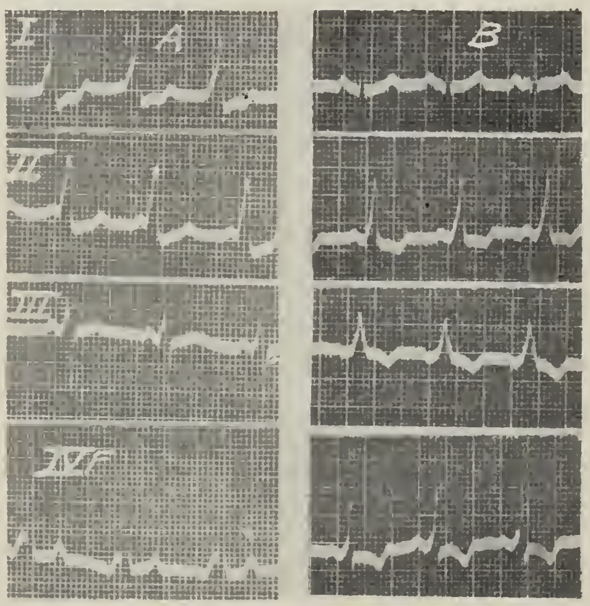

FIG. 10. A—Case 3; B—Case 4.

The mechanism of production of the syndrome has been discussed. The experimental data presented are in agreement with previously published reports. Suggestions have been offered as to resolving the apparent inconsistencies in observed data in the literature, particularly those concerning the effect of the parasympathetic and sympathetic nervous systems.

The present case 1 is the only one so far published in which both quinidine and digitalis caused a reversion to normal rhythm.

It has already been mentioned that there is difficulty in some instances of distinguishing whether the patient has organic heart disease in some instances of this syndrome. This is well illustrated in case 1.

CONCLUSIONS AND SUMMARY

1. Four cases of the syndrome of premature ventricular excitation have been presented.

2. Illustrative and experimental data on these cases have been presented.

3. Attention has been called to the fact that when heart disease is present in these cases it is present only coincidentally, and that in a few instances it is difficult to distinguish organic heart disease, especially coronary arteriosclerosis, when it is present.

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THE TOXICITY AND POTENTIAL DANGERS OF DDT TO HUMANS AND WARM-BLOODED ANIMALS*

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SINCE the early spring of 1943 the Industrial Hygiene Research Laboratory of the National Institute of Health has been engaged in the study of the toxicity and potential dangers of DDT to humans and warm-blooded animals when used as a dust, spray, mist, and aerosol. The study was undertaken at the request of the Office of the Surgeon General, U. S. Army, and the Bureau of Entomology and Plant Quarantine, U. S. Department of Agriculture. The work of our laboratory supplemented the work of the late Dr. H. O. Calvery, Food and Drug Administration; Dr. M. I. Smith, Division of Physiology, National Institute of Health; and Dr. Robert Kehoe, Kettering Laboratory, University of Cincinnati.[1–9]

The successful use of DDT as an insecticide by the armed forces, and its availability on a relatively large scale give promise of its widespread use as an agricultural and household insecticide. It is evident, therefore, that detailed toxicologic data on the effect of DDT on humans is of primary importance, because of the intimate and continuous cutaneous exposure of individuals using it as lousicide; the respiratory and cutaneous exposure of individuals using it as a spray, mist, aerosol, or powder in confined quarters; and the possibility of ingestion through accident or from contamination of vegetables or other foodstuffs with DDT.

DDT is a white, crystalline powder, very insoluble in water but soluble in oils and certain organic solvents. It is tasteless and, when pure, practically without odor. When DDT is applied in solutions, emulsions, or as a powder, it adheres to any surface with which it comes in contact, and for this reason it is not very liable to form a dust upon agitation of the air. The development of DDT insecticides has been accompanied by changes in the methods of application of insecticides, inasmuch as it has been found necessary to decrease the particle size of the mist, spray, aerosol, and smoke to relatively small particles or droplets. Since the absorption through the respiratory tract and the penetration into the alveoli depend largely upon the particle size, the use of aerosols, smokes, and power sprayers produces particles which can be absorbed through the lower sections of the respiratory tract. Because of the relatively small amount of DDT present in insecticidal mixtures necessary to produce the desired insecticidal effect, the actual concentration of DDT in the air is relatively small. However, there is considerable contamination from the solvents used.

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* Read before the Society, November 14, 1945.

Therefore, in many instances the major exposure by different routes is the solvent. It may be pointed out that any solvent suitable for this purpose is liable to cause irritation of the skin, due to the same physico-chemical properties which render it valuable as a DDT solvent. For the same reason they cause also irritation of the mucous membranes, and in sufficient concentrations may cause systemic effects such as nausea, vomiting, fatigue, headache, and other nervous system manifestations. The various governmental and other agencies participating in the development of DDT insecticides have recognized this danger and they have recommended only such solvents which are the least harmful. It should at this time be pointed out that the chlorinated hydrocarbons such as carbon tetrachloride and especially tetrachloroethane should not be used as solvents for DDT.

At least 12 different species of warm-blooded animals have been studied with regard to their sensitivity to DDT. It was found that the lethal dose of DDT with any route of administration varied considerably with different species, ranging from about 250 mg. per Kg. for mice to over 1,000 mg. per Kg. for goats. It has also been found that as a rule young animals are more susceptible than adult ones.

DDT can be absorbed through the gastrointestinal tract, the respiratory tract, and if applied in oily solution also through the skin in contrast to the dry powder which is not absorbed by this route. In the use of DDT insecticides for domestic animals it should be kept in mind that some species, especially cats, have a tendency to clean themselves by licking their fur. It is obvious that in such cases considerable amounts of DDT may be absorbed through the gastrointestinal tract and thus give rise to toxic symptoms.

The symptomatology of animals suffering from DDT poisoning is characterized by hyperexcitability, nervousness, generalized tremors, clonic-tonic type of convulsions, and coma ending in death. The convulsions resemble closely those seen in strychnine poisoning in that they can be elicited by mechanical stimuli, such as sudden noise and jarring. It should be pointed out that even in fatal acute or often in chronic poisoning the pathologic changes found are not sufficiently marked to account for death, and it appears, therefore, that the mechanism of action of DDT is essentially of functional character. This is also brought out by the observation that animals may recover even from severe DDT poisoning without any observable untoward effects.

The most careful liver and kidney function tests have failed to reveal a definite hepatotoxic or nephrotoxic action of DDT. Nor is there any definite evidence of an injurious effect on the blood picture, blood chemistry, or blood-forming organs.

With regard to the fate of DDT in metabolism, we have found that in rabbits DDT is partly oxidized to bis(p-chlorophenyl)acetic acid. Whether this is further changed to bis(p-chlorophenyl)methane or other metabolites has not yet been established. In both animals and humans the acetic acid metabolite (DDA) has been recovered from the urine. Schechter and Haller of the Bureau of Entomology and Plant Quarantine, U. S. Department of Agriculture, have developed methods for the determination of DDT and DDA which give excellent results in the hands of experienced chemists but are somewhat too involved for routine clinical laboratory use at present.

In both animals and humans the organic chlorides of the urine have been found to be increased following DDT ingestion. Again the chemical procedure hardly lends itself to routine clinical use. The interpretation of this increase is also rather difficult.

Pure DDT does not cause irritation of the skin in either animals or humans, nor is there definite evidence of a sensitizing effect on the skin or of production of other allergic reactions such as asthma. It should, however, be emphasized that certain solvents used in the preparation of DDT mists, sprays, and aerosols are in themselves skin irritants with sufficient exposure. In addition it should be pointed out that contamination of the skin with some of these solvents may cause such symptoms as paresthesias and anesthesias. It should also be emphasized that the symptoms produced by these solvents, either locally or systemically, set in rather promptly, whereas those symptoms produced by DDT develop only after a latent period of several hours.

The principal histopathologic finding in animals exposed to high concentrations of DDT is moderate subacute degeneration of the liver. Histopathologic changes in the brain and spinal cord of animals dying with typical DDT tremors are very slight. Often the histopathologic changes found are insufficient to account for the death of the animals.

With regard to the toxicity of DDT for humans the following may be stated: Exposure of 2 human subjects to a dispersion of DDT in air, prepared by dispensing, every 15 minutes, 10.4 Gm. of an aerosol containing 5 per cent DDT, 10 per cent cyclohexanone, and 85 per cent "Freon" into a sealed chamber of 14,750 liters capacity, for 1 hour daily, on 6 consecutive days, failed to show any subjective or objective manifestations referable to DDT.

Dispersion of 10.4 Gm. of DDT aerosol of the same composition, every 5 minutes, for 1 hour daily, on 5 consecutive days, also did not cause any subjective or objective toxic effects referable to DDT in the same subjects.

It should be pointed out that the exposure of these 2 individuals 2½ years ago to DDT aerosol was at least 10 times as severe as would result from the household use of a single DDT aerosol bomb.

One year later one of the above individuals was given 475 mg. of DDT dissolved in olive oil by mouth on an empty stomach. A thorough physical examination, including neurologic, biochemical, hematologic, and psycho-physiologic examinations as well as liver function tests, both before and after the ingestion of DDT, failed to reveal any subjective or objective evidence of untoward effects. Evidence of absorption of DDT was proven by the increase of organic chlorides in the urine.

Two months ago the same individual ingested 11 mg. per Kg. of DDT dissolved in olive oil on an empty stomach. This amounted to 770 mg. for a single dose. The same type of physical examination as noted above was given before and after the ingestion of DDT, and in addition electroencephalograms and electrocardiograms were taken and the blood sugar was determined at 2-hour intervals for about 10 hours. These various examinations gave no evidence of untoward effects from the ingestion of 770 mg. of DDT.

Twenty-four-hour urine specimens were collected over a period of 2 weeks prior to the ingestion of DDT and for 2 weeks afterward. The amount of the metabolite bis(p-chlorophenyl)-acetic acid and organic chlorides in the urine was determined. These analyses are not yet complete. Both DDA and organic chlorides were found in the urine using the Schechter-Haller test for the former and the method of Winter as modified by Hall and others for the latter. The peak of the DDA excretion occurred in the second 24-hour urine specimen and thereafter decreased gradually; however, small amounts were still present in the urine 2 weeks after the ingestion of DDT. The peak of the organic chloride content in the urine occurred in the first 24-hour specimen and thereafter gradually decreased.

So far we have been unable to recover DDT per se from the urine.

The prolonged excretion of DDA and organic chlorides after a single dose is probably due to the fact that DDT is stored in fat tissues and gradually released. Animal experiments by the Division of Pharmacology, Food and Drug Administration, and by the U. S. Department of Agriculture have shown that DDT is stored in fat tissues and is also excreted in the milk, as determined by the Schechter-Haller test and bioassay with flies. It should be pointed out, however, that the quantities recovered have been very small compared to the amount of DDT given, so that it appears very unlikely that the ingestion of meat or milk of animals exposed to DDT under the normal use of DDT-containing insecticides would cause untoward effects in man.

With regard to the repeated exposure of human beings to small amounts of DDT, it is our opinion at this time that on low dosages of DDT there is practically no cell damage. However, DDT is stored in the tissues, and there is an accumulation but no cumulative damage.

In August, 1944 a thorough clinical and laboratory study was made on 3 men each of whom had had several months of continuous occupational exposure to DDT when used as a mist and dusting powder. The exposure of 2 of these individuals to DDT was extremely great, more so than necessary for the work they were doing, during the 3½ months from October, 1943 to the middle of January, 1944. The third individual whose exposure had been somewhat less than the other 2 individuals had had constant exposure for the 9 months prior to the time of the examination. The results of the clinical and laboratory examinations of these 3 men can be summarized in the statement that after carefully evaluating all the evidence accumulated from the examination of each case we were led to the conclusion that none of them presented definite findings that could be attributed to the toxic action of DDT.

In September, 1944 four individuals were studied thoroughly, using clinical and laboratory methods both before and after they were subjected to exposure to DDT in the course of experimental field tests of a recently designed DDT aerosol smoke generator. An evaluation of the findings revealed no definite evidence of DDT toxicity in these individuals.

Since the introduction of the use of DDT by the armed forces, the Army, the Navy, the Bureau of Entomology and Plant Quarantine, U. S. Department of Agriculture, the Food and Drug Administration, the Office of Scientific Research and Development, the U. S. Public Health Service, and other groups have brought to the attention of this laboratory all suspected cases of DDT poisoning in humans. This laboratory has traced each case brought to its attention, and in some instances has hospitalized the individuals for intensive study. To date no cases have been discovered in which the signs and symptoms were considered to be due to DDT per se. In several cases the solvent for DDT was found to cause irritation of the eyes and upper respiratory tract, as well as such symptoms as headache, nausea, tingling sensations of the lips and face, nervousness, or jittery feeling, listlessness and loss of equilibrium.

Although we have not seen any cases of DDT poisoning in humans, it is our opinion that the same toxicologic picture should prevail in human cases of DDT poisoning as seen in animal experiments which are mainly characterized by nervous system manifestations. There is not sufficient evidence at present to allow the assumption that DDT poisoning should cause severe organic injury of the liver or kidney or of any other organ.

With regard to the treatment of DDT poisoning, since there is no specific antidote, the treatment has to be symptomatic. It is of paramount importance to prevent further absorption by removing any contamination from the skin by washing with soap and warm water, or in case of ingestion, by removing it from the stomach by gastric lavage with warm water or from the intestine by saline cathartics. Castor oil or other fatty cathartics or emulsions should not be used. In case of nervous manifestations, such as tremors and convulsions, animal experiments indicate that these can be controlled by phenobarbital, which may prove life-saving even in severe cases.

In view of the extensive use of DDT as an insecticide, well over a million humans have been exposed to DDT. It is obvious that some of these will develop diseases, the true characters of which are not readily diagnosed, and therefore easily credited to exposure to DDT.

In summary, it may be stated that DDT is definitely less toxic than Paris green or sodium fluoride. Nevertheless, DDT has toxic properties which require certain precautions in its use.

DDT is absorbed from the gastrointestinal tract after ingestion and through the lungs after inhalation, whereas the dry powder is not absorbed through the skin. It has, however, been shown that when dissolved in oil it is more readily absorbed from the gastrointestinal tract and is also absorbed through the skin. Contamination of skin and garments with concentrated solutions of DDT in oily solvents should be avoided, and any spills should be removed as soon as possible by washing with soap and water.

In spite of the inherent toxicity of DDT, no toxic symptoms have been observed in animals exposed to an atmosphere containing many times the recommended insecticidal concentration of DDT as aerosol, spray or dust. But since intimate contact with the skin and exposure to abnormally high concentrations may cause toxic effects, it is essential that the directions given for its use as a household insecticide be followed carefully. In animals, 100 mg. per Kg. of body weight by mouth produced no toxic effects, but larger doses caused tremors, convulsions, and incoördination, and may cause death. Although it appears unlikely that food contaminated with DDT from the domestic use of DDT insecticides under optimal insecticidal conditions will cause toxic effects in man, such contamination should be avoided by removing the food from the rooms or by covering it with paper during spraying.

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A STUDY TO DETERMINE THE ANTIBACTERIAL EFFICIENCY OF COMBINED TYROTHRICIN AND SULFADIAZINE

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THE purpose of this study was to determine the in vitro efficiency of a mixture of sodium sulfadiazine and tyrothricin, such mixture known commercially as Sulfathricin*, as a bactericidal agent against those organisms commonly found in the upper respiratory tract, ear, and infected sinuses.

Tyrothricin, the alcohol-soluble, water-insoluble extract of peptone cultures of Bacillus brevis, is a mixture of at least two substances which have been separated as the crystalline compounds, gramicidin and tyrocidine. Tyrothricin in a 1:2000 dilution and sodium sulfadiazine in a 2 per cent concentration were present in the preparation called Sulfathricin used in this study.

Gram-positive bacteria against which tyrothricin is effective in vitro include streptococci, staphylococci, pneumococci, and diphtheria bacilli. These organisms are, incidentally, the ones commonly encountered as causes of infections involving skin, soft tissues, nasopharynx and accessible body cavities, such as the paranasal sinuses. The high in vitro antibacterial activity of tyrothricin and its components have been the subject of reports by Dubos,[1,2] Hotchkiss and Dubos,[3] Goodman,[4] Herrell and Heilman,[5–9] Tishler, Stokes, Trenner and Conn,[10] Christensen, Edwards and Piersma,[11] and others.

Tyrothricin is nontoxic but without therapeutic effect when given by mouth. It is both dangerous and ineffective when given by intravenous or intramuscular injection. On local application, its toxicity for tissues is quite low, and it has been widely employed topically and by instillation and irrigation in accessible body cavities without untoward effects.

The literature concerning the antibacterial activity of sulfadiazine is voluminous. It may suffice to say that in general the following organisms are susceptible to its action: Beta hemolytic streptococci, pneumococci, meningococci, gonococci, staphylococci, and Friedländer's bacillus.

The above mixture has been commonly used in the treatment of chronic upper respiratory infections and certain types of vaginitis, cervicitis, and otitis externa.

The purpose of this investigation was to determine the in vitro antibacterial properties of a combination of tyrothricin and sodium sulfadiazine in order to discover whether the two chemicals combined would be more efficacious than either alone when used against bacteria commonly found in the upper respiratory tract. The organisms used for this study were either isolated in pure culture from human throats, sputa or nasal secretions, or obtained from the culture collections at the National Institute of Health, Bethesda, Maryland. It will be noted that several organisms are included in this list that are not ordinarily present in the upper respiratory tract. These were observed for control purposes.

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* Material for testing supplied through the courtesy of the manufacturers, International Chemicals, Washington, D. C.

The technic used for this study was as follows: The organism, isolated in pure culture, was grown on a beef infusion agar stab and kept as a stock culture. A loopful of the stock culture was transferred to a tube of beef infusion broth and incubated at 37°C. for 12 hours. This tube was diluted 1:10 with sterile broth, and 0.1 c.c. of tyrothricin-sodium sulfadiazine suspension* was added. A similar tube was prepared, and 0.1 c.c. of 2 per cent sodium sulfadiazine was added, and a tube containing 0.1 c.c. of 1:2000 tyrothricin was also prepared. A control tube of the 1:10 suspension was used. All tubes were incubated at 37°C. for 6 hours, and then transferred to a Klett-Summerson photoelectric cell colorimeter, using the number 54 green filter and adjusting the indicator to zero position with a control tube of sterile broth.

Table 1 shows the results of these observations.

A series of tests were carried out during a 3 months' period, and the combined solution remained quite stable as far as its antibacterial action was concerned. Newly prepared solutions gave results which were comparable to those prepared 3 months previously.

TABLE 1

ORGANISM	CONTROL	SODIUM SULFADIAZINE		TYROTHRICIN		COMBINATION	
	Colorimeter reading	Colorimeter reading	Inhibitory effect	Colorimeter reading	Inhibitory effect	Colorimeter reading	Inhibitory effect
Staph. aureus	56	43	+	41	+	35	++
Staph. albus	62	40	+	38	+	36	++
Strept. hemolyticus	44	29	++	27	++	26	+++
Strept. fecalis	30	30	0	21	++	21	++
Friedlander's A	48	32	+	45	0	36	+
Friedlander's B	87	55	+	88	0	61	+
N. intracellularus	29	24	+	27	0	25	+
N. catarrhalis	42	29	+	24	++	30	+
C. diphtheriae	28	27	0	19	+	22	+
C. pneumoniae	37	30	+	22	++	24	+
S. paratyphi	66	63	0	64	0	63	0
S. interitides	86	80	0	75	+	84	0
E. coli	69	64	0	73	0	66	0

CONCLUSIONS

It would appear from the above observations that at least in vitro a combination of tyrothricin and sodium sulfadiazine is more efficacious as an antibacterial agent than either alone when used against organisms frequently found in the upper respiratory tract, and tends to confirm clinical findings.

Furthermore, the solution-suspension appears relatively stable.

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THE SUCCESSFUL USE OF ORAL PENICILLIN IN THE TREATMENT OF SUBACUTE BACTERIAL ENDOCARDITIS*

Report of a Case

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RECENT reports in the literature indicate that cures may be effected in cases of subacute bacterial endocarditis when an adequate dosage of penicillin is administered. Following initial discouraging observations,[1] Loewe et al[2] achieved successful results in 7 consecutive cases of subacute bacterial endocarditis using combined penicillin-heparin therapy. More recently Loewe[3] reported 75 per cent cures in 54 consecutive cases. Similarly, other authors[4, 5, 6, 7] observed successful therapeutic results in 50 to 75 per cent of cases (see table 1).

In all of these patients the parenteral route of administration of penicillin was used, including continuous intravenous and intramuscular, and intermittent intramuscular injections. Because of the difficulties concerned in this manner of treatment, the oral method of administration was thought to offer definite advantages. It was determined in a series of preliminary experiments[7] that adequate penicillin blood levels could be obtained when the drug is protected from the inactivating influence of the hydrochloric acid in the stomach. Penicillin concentrations obtained after the ingestion of 100,000 units of powdered sodium penicillin in a double gelatin capsule compared favorably and in some respects surpassed those obtained after the administration of 40,000 units given parenterally. Characteristic of the curves obtained after the oral administration of 100,000 units was the rapid appearance of large amounts of penicillin in the blood stream with the highest levels demonstrable in the first 30 to 90 minutes after ingestion, and the continued presence of therapeutic levels of penicillin for at least 3 hours. The ingestion of a second 100,000-unit capsule 3 hours after the first dose produced an incremental rise in the penicillin titer similar to the initial 3-hour curve. It seemed justified to conclude that when these capsules were ad-

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* From the Medical Service, Children's Hospital, Washington, D. C., aided by a grant from the George Washington University School of Medicine.

ministered every 3 hours, therapeutic concentrations of the drug were maintained constantly. The average maximum levels observed ranged between 1.24 and 2.48 Florey units. In a clinical evaluation of oral penicillin[8,9] it was found that ready cures of susceptible infections could be effected when this method of administration was employed. It was therefore deemed of singular interest to attempt to treat a case of subacute bacterial endocarditis with oral penicillin. To our knowledge the present case report represents the first successful treatment of bacterial endocarditis with oral penicillin.

METHODS AND MATERIALS

The contents of an ampule containing 100,000 units of powdered sodium penicillin was transferred to a plain gelatin capsule (no. 1) which was moistened and sealed and in turn placed in a second capsule of the next larger size (no. 0). The double capsule containing the penicillin was then hardened by placing it in a solution of formaldehyde U.S.P. diluted 1:20 for 5 seconds followed by immersion in 95 per cent alcohol for 5 minutes. The purpose of the double capsule was to

TABLE 1

AUTHOR	NO. OF CASES	DURATION OF INFECTION	SENSITIVITY TO PENICILLIN	DAILY DOSAGE	TOTAL DOSAGE	ROUTE OF ADMINISTRATION	DURATION OF TREATMENT	HEPARIN	RESULTS	FOLLOW UP
				units	*units*					
Loewe	54	1 week to 19 months	0.007–0.5	40,000–1,000,000	367,000–18,930,000	Continuous IV	not given	Used in all cases	74% recovery, 26% failures	2–15 months
Dawson and Hunter	20	1 to 15 months, average 2 months	0.008–0.14	40,000–500,000	830,000–36,700,000 average 6,700,000	Intermittent IM Continuous IV Continuous IM	10–103 days, average 30 days	Given in 16 cases. Other 4 cases did not receive it.	15 cases or 75% recovery, 3 cases or 15% died, 2 cases or 10% relapsed.	1–10 months, average 6 months
Keefer et al.	17	not given	not given	not given	240,000–1,760,000	not given	9–26 days	not given	10 cases or 59% no effect, 4 cases or 23% died, 3 cases or 18% improved, 2 cases or 12% relapsed.	not given
Meads, Harris and Finland	9	2 weeks to 6 months, average 2 months	0.011–0.031	90,000–480,000	1,860,000–5,900,000, average 4,600,000	Chiefly Intermittent IM	6–19 days, average 17 days	Given in 3 cases. Other 6 cases did not receive it.	66% recovery, 22% relapsed, 11% died.	1–10 months, average 5 months
Spink and Hall	8	not given	not given	4 patients 240,000, 4 patients not given	4 patients 4,200,000, 4 patients less than 1,000,000	IV every 12 hours	17 days	none	? 50% cured	not given
Paullin and McLoughlin	6	1 to 24 weeks, average 7 weeks	not given	200,000–300,000	2,800,000–4,500,000, average 3,700,000	Intermittent IM	14–20 days	none	50% cured	1–6 months

provide additional mechanical protection for the penicillin.

In 2 instances during the course of treatment penicillin levels were assayed at hourly intervals during consecutive 6-hour periods to determine whether the penicillin blood concentrations were in excess of the susceptibility range of the Streptococcus viridans organism. Penicillin content was assayed according to the method of Rammelkamp,[10] B. hemolyticus streptococcus 203 being used as the indicator organism. Blood samples after withdrawal were immediately placed in the icebox and were usually examined within 2 or 3 days.

Report of Case

M. P., an 11-year-old white girl, was seen on April 4, 1945 by one of us (B. J. W.) and a diagnosis of interventricular septal defect and probable subacute bacterial endocarditis was made. She was admitted to Children's Hospital the same day.

A heart murmur was first noted when she was 1½ months old. Cyanosis and dyspnea were not present at any time. Her development had been normal, and her past history was essentially negative. Four weeks prior to admission she complained of easy fatigability and copious night sweats, and a persistent fever with daily temperature elevations was observed.

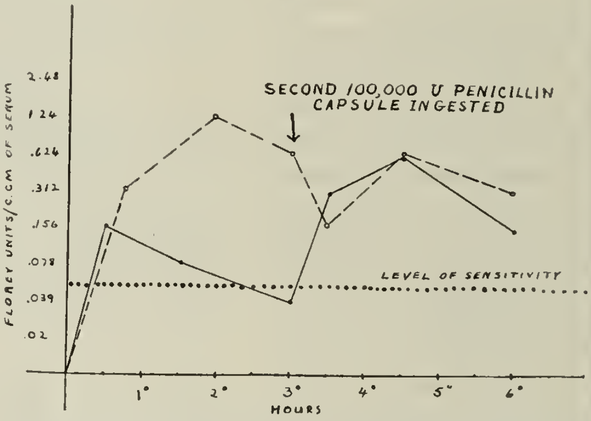
Physical examination revealed a well developed and nourished adolescent female who appeared pale but not acutely ill. Her temperature was 103°F., respirations were 27, and the pulse rate 128. No petechiae were noted. The second left upper molar tooth was decayed and loose. A harsh, loud, systolic murmur with maximum intensity in the third and fourth interspaces about 2 cm. to the left of the sternum was present and was transmitted over the entire precordium. There was an intense systolic thrill in the area where the murmur was loudest. The spleen was not palpable and the remainder of the physical examination was negative. An electrocardiogram was normal. A roentgenogram of the chest showed moderate enlargement of the right and left ventricles.

Three blood cultures, taken on April 21, 22 and 24, showed the presence of 30, 44, and 12 colonies respectively of Streptococcus viridans per c.c. of blood. The strain showed a sensitivity range to penicillin of from 0.05 to 0.1 Florey units.

Repeated sedimentation rates were very rapid, and hemograms gave evidence of a moderate degree of anemia. The temperature curve during the first 2 weeks under observation showed a daily rise between 100°F. and 103.4°F. A small painful red area appeared on the sole of the right foot on the tenth hospital day and was considered to be due to an embolus.

Specific therapy was started on April 29, 1945. Sodium penicillin was prepared in double gelatin capsules, and 100,000 units was given every 3 hours. Preliminary neutralization of the gastric acidity was obtained by the administration of 2 aluminum hydroxide tablets 15 to 30 minutes before each dose of penicillin. The patient was given a soft, fat-free diet with moderate limitation of fluids, and her feeding schedule was slightly changed so that at no time was the penicillin given simultaneously with a meal.

CHART 1



Penicillin blood levels obtained on the patient while under treatment during 2 random 6-hour periods after oral administration of 100,000 units every 3 hours. Note the incremental rise in Penicillin titer after ingestion of 2nd capsule. The sensitivity level of the Streptococcus viridans is indicated, and, as can be observed, the penicillin blood levels usually substantially exceed the sensitivity level.

Eight hours after the initiation of oral penicillin the temperature fell from 102°F. to normal and remained normal thereafter except for a transient rise to 100°F. on the ninth day at the time of the extraction of her decayed tooth.

A blood culture obtained 12 hours after the start of treatment showed no growth, and daily blood cultures taken during the entire period of 2 weeks the patient received penicillin were negative. Penicillinase was added to the broth in one of these blood cultures and no growth was observed.

Penicillin serum levels were assayed at various intervals during the 2 weeks of therapy and adequate therapeutic amounts of the drug were always demonstrable in the peripheral blood. As will be noted in chart 1 the effect of a successive dose of penicillin was to produce an incremental rise in the existing titer and so maintain a constant therapeutic blood level. The patient received 100,000 units of penicillin as a single dose every 3 hours for 14 days, a total dose of 11,200,000 units. No toxic symptoms were observed. Blood counts taken every other day were all normal; however, the sedimentation rate remained moderately rapid. Five blood transfusions of 250 c.c. each were given over a period of 2 weeks to correct the anemia.

The patient was observed in the hospital for an additional 9 days after oral penicillin had been discontinued, and blood cultures during this period were negative. She was discharged on May 21, 1945 and was examined every 2 weeks for the ensuing 4 months. The child was given complete freedom in her range of activities except for the avoidance of exhaustive play. A daily temperature reading was recorded. She has remained entirely afebrile, numerous blood counts have been normal, and 17 blood cultures obtained at intervals during this observation period of 4 months have consistently remained sterile. The sedimentation rate taken on July 23, 1945 was 22 mm. in 1 hour (Wintrobe method). She has gained 15 pounds in weight. A roentgenogram reveals no change in the cardiac dimensions.

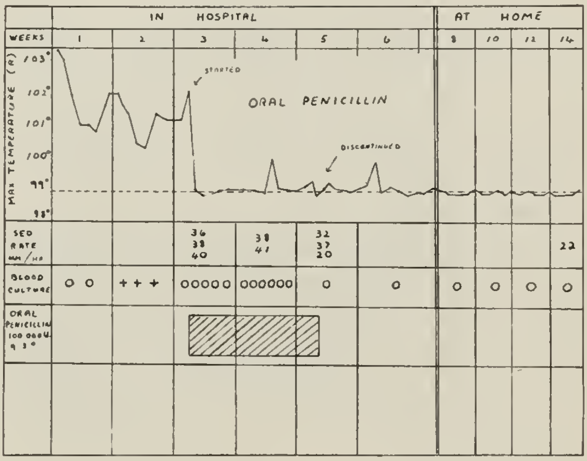
DISCUSSION

The clinical course of the case presented here has been summarized in chart 2. The striking defervescence of fever 8 hours after penicillin had been started and the prompt sterilization of the peripheral blood are to be noted. The patient received penicillin for an arbitrarily selected period of 14 days, during which time the suspected portal of entry, the decayed tooth, was removed. Clinically she was greatly improved and manifested a degree of well-being during the remainder of her hospital stay. At no time either during or following therapy were any embolic phenomena observed.

The sensitivity of the invading strain of Streptococcus viridans in this case ranged between 0.05 and 0.1 Florey units. In preliminary experiments previously cited[7,8] the penicillin concentrations, obtained for a 3-hour period, when 100,000 units were ingested, produced levels that were considerably in excess of this susceptibility range. It was, therefore, decided to administer this dose every 3 hours, having reasonable assurance of constantly effective blood levels of penicillin. Chart 1 represents the resultant curves of penicillin assays obtained on 2 separate 6-hour periods, selected at random intervals while this patient was receiving the drug. It will be noted that the concentrations obtained ranged between 0.078 and 1.24 Florey units per c.c. except in one instance when the blood level was 0.039 Florey units per c.c. at the end of 3 hours. These levels were within or well above the susceptibility range of the invading organism.

CHART 2

Summary of Clinical Course



Fourteen days were arbitrarily chosen as the period of treatment, to be varied by the clinical course and the repeated blood cultures. During this time a total dose of 11,200,000 units of penicillin was given, which is approximately twice the total amount reported to have been administered to cases of subacute bacterial endocarditis when the parenteral method was employed (table 1). It is not possible to state whether or not oral penicillin could have been discontinued before the 14-day period had been completed. In this regard it is of interest to note that the temperature became normal and the blood cultures negative 12 hours after treatment had been started.

The advantages of administering penicillin by mouth to cases of subacute bacterial endocarditis are especially manifest because of the length of time during which therapy must be maintained. Discomfort to the patient incurred by parenteral administration is thus avoided. When the intermittent intramuscular mode is employed a total of 200 to 300 separate injections are required and undoubtedly are a source of considerable physical and psychic trauma. Using the continuous intravenous method of giving penicillin, Loewe[3] observed a relatively high incidence of toxic reactions including thrombophlebitis, fever, chills, local pain and troublesome instances of regional angiitis. The danger of thrombophlebitis is especially real when this method is employed for the treatment of subacute bacterial endocarditis in view of the fact that therapy is continued for 3 to 5 weeks. Congestive heart failure is not an infrequent complication of endocarditis, and in such cases the administration of excessive amounts of fluid, entailed by the intravenous route, would be contraindicated.

The disadvantages of these parenteral routes are obviated when penicillin is given by mouth, and the management of cases of subacute bacterial endocarditis is definitely simplified for the hospital personnel.

No subjective or objective toxic manifestations were observed in this case.

The advisability of the use of heparin in conjunction with penicillin in the treatment of this disease is controversial. Dawson and Hunter[4] reported that 5 patients in their series received penicillin alone, and the results were thought to be as satisfactory as when heparin was used. Similarly, in the series of 9 cases reported by Meads et al,[5] heparin was employed in only 3 patients and no essential variation in the 2 groups was noted. Loewe,[3] on the other hand, recommends the routine use of combined heparin-penicillin treatment for bacterial endocarditis. Because heparin has not been demonstrated to have any distinct advantage over penicillin alone and since its use is not without danger in view of its well known variable effect on the clotting time of the blood, it was not employed in our case.

CONCLUSIONS

1. The successful use of orally administered penicillin in the treatment of a case of subacute bacterial endocarditis is reported.

2. The dosage consisted of 100,000 units of powdered sodium penicillin in a double gelatin capsule every 3 hours for 14 days, totaling 11,200,000 units.

3. No subjective or toxic symptoms were noted.

4. In a follow-up period of 8 months the patient has remained afebrile, has shown persistently sterile blood cultures, and has been completely asymptomatic. It would seem reasonable to conclude that a cure has been achieved.

5. The definite advantages of oral penicillin for this disease are manifest because of the comparative ease of administration.

The authors wish to express their appreciation to Drs. Joseph Wall and E. Clarence Rice of the Medical Research Committee of Children's Hospital, Washington, D. C., for their helpful suggestions and advice and to Miss Betty Porter for her technical assistance.

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(*Continued on page 54*)

President's Page

"... I WAS VERY MUCH IMPRESSED"

Early in December Dr. Coursen B. Conklin, Dr. Herbert P. Ramsey, Secretary Theodore Wiprud and your President went to Chicago to attend the meeting of the House of Delegates of the American Medical Association. It was the first time I had seen that body in session and I was very much impressed. As in all legislative bodies, most of the work was done by reference committees which, after hearings and deliberation, submitted recommendations to the House.

An older and more conservative group seemed to make up the majority of the membership of the House. However, there were also a number of younger, more adventurous, keenly alert delegates who seemed very much alive to the current medical trends. They made themselves heard from time to time during the three days that the House was in session, and made a vigorous fight for certain resolutions they felt should be adopted.

This younger group was led by delegates from California, where they had recently been instrumental in defeating compulsory health insurance legislation. Some of the resolutions which they fought for were defeated. But they did succeed in getting one of their members elected to the Council, which must have given them satisfaction.

All of us were tremendously impressed by Dr. Roger I. Lee, President of the American Medical Association. His address made it plain that we have a great leader for the coming year. Dr. H. H. Shoulders, formerly Speaker of the House and now President-elect, also made a most excellent address on "The Soul of Medicine."

The high spot of the meeting to those of us from Washington was the favorable report on the resolution introduced by Dr. Conklin, our Delegate, at the request of our Executive Board, providing that the House instruct the A.M.A.'s Council on Medical Service and Public Relations to proceed promptly with the development of a specific national health program with emphasis on the nation-wide organization of locally administered medical prepayment plans sponsored by medical societies. It was adopted almost word for word, and we felt that the Medical Society of the District of Columbia which for some time had vigorously urged the A.M.A. to come out with a national health program, had been largely instrumental in bringing it about. This program, when it has been consummated, should make medical care more readily available to millions of our citizens.

Wm. Earl Clark

Editorials

OUR TASK IN 1946

The predominant attitude of our people at the beginning of 1946 is one of uncertainty about the future. In this respect physicians are no exception. For they, too, have a feeling of insecurity, being particularly disturbed by trends in the postwar world.

Are we going to follow the lead of other nations who are veering to the left? There are certainly signs pointing in that direction. In fact, some hard-headed leaders assure us that we are traveling rapidly toward a socialistic state. If this be true, the medical profession cannot escape regimentation. But is it true? That is one of the uncertainties which concern physicians most. Only time holds the answer.

What of the certainties? It is quite clear that physicians must be willing to make adjustments demanded in the new world. This is not going to be easy. There will be many who will find it difficult, if not impossible to do. To make it more tolerable to the less resilient will challenge the best efforts of organized medicine. Issues confronting medicine in a complex and sometimes chaotic world cannot be met by individuals. Survival of the best in medicine will depend upon a unified and strongly organized medical profession.

Medicine's greatest responsibility in the coming year is to provide for unmet medical needs. New methods will, of necessity, have to be adopted. Physicians have already heard a great deal about voluntary sickness insurance as one means by which this can be done. At its best, this will be only a partial solution. However, if adequately organized on a nation-wide basis, it will be a good beginning.

Beyond this, medical societies must reorganize themselves so they can resume their peacetime activities. These activities are numerous and include health education, broader application of preventive medicine, and a more adequate scientific program for physicians.

From a social and economic point of view, the most important matter to be considered by the Medical Society of the District of Columbia this year is the medical prepayment plan on which the Subcommittee on Prepaid Medicine and the Committee on Medical Care have been working for several months. This plan will be submitted to the Society sometime early in the year. The Society will then have to decide whether it intends to join the majority of medical societies in this country in furthering the establishment of prepaid medicine. It is one of the most vital decisions our Society has been called upon to make.

It can readily be seen, then, that hard work and many responsibilities lie ahead in 1946. And, if its past record is a criterion, the Society will measure up to demands upon it. T. W.

NURSING HOMES

A recent fire in Hartford, Conn. in which 17 residents of a "home" for elderly people died serves to direct attention again to a substantial group of institutions which, though not hospitals, are among the fringe of medical facilities.

These "convalescent homes" or "nursing

homes," by whatever title they may be known, serve a useful purpose in relieving hospitals of a load of chronic and convalescent patients for which the latter type of institution is not designed to care. They have developed gradually—so gradually that they have largely eluded regulation, despite their clearly medical character. In these "homes" we find persons recuperating from illness, operation, or childbirth; diabetics; hemiplegics; or perhaps alcoholics and other mental patients. Some are bedfast, and most of them are unable to move about freely.

It might be assumed that such medical facilities would be subject to some sort of inspection and control. The need of suitable medical supervision, available both routinely and in emergency, and of nursing care by competent persons is, or should be, self-evident. Yet the extraordinary fact, here in the Nation's Capital, as well as in some other jurisdictions, is that the only control which can be exercised by the Health Department is authorized by the law relating to rooming and boarding houses! No argument is needed to support the thesis that the regulations relative to the number of beds, the amount of day room space, and the number and accessibility of baths and toilets which may be entirely proper for a house in which young and vigorous people, out at work during the day, are living may be highly inadequate for a group of equal size of the elderly and infirm. In the matter of fire regulations, the law seems sufficient; the Building Department has jurisdiction the same as for hospitals, although the Health Department has not!

The definitions in the District laws might well be clarified and the jurisdiction of the Health Department should certainly be extended. Any receptacle, by whatever name it passes, which cares for the sick and infirm of any type, should be compelled to meet certain minimum requirements of safety and comfort, and to be in addition provided with adequate medical and nursing care. In these days when much is being said concerning health needs, the care of the chronically ill should not be permitted to escape attention.

W. O.

THE AGE TREND

Can any trend be observed in the ages of officers and trustees of the American Medical Association? There is not yet enough change to establish a trend, but certain observations may be made which may be significant.

Previous communications[1, 2] on the subject of age attempted to analyze the ages of the members of the House of Delegates and of officers and trustees of the A. M. A. in an effort to provoke thought as to whether age might be a factor in the official activities of these functionaries.

No effort is being made now to study the ages of the members of the 1945 House of Delegates, but there follows a tabulation of the ages of the officers, trustees, and members of the Council on Medical Service and Public Relations in 1944–45 and 1945–46. The ages shown are those of the year in office indicated; hence the age for an individual in the 1945–46 roster is shown as one year greater than in the 1944–45 roster if it appeared there also.

It may be observed that a 65-year-old president is succeeded by a 64-year-old president, and that the president-elect is 59, 5 years younger.

A Board of Trustees of average age 63.1 is succeeded by a Board of average age 60.4+; this was accomplished by the election of 3 new trustees aged 51, 57, and 59, to succeed 3 outgoing trustees of 63, 64, and 70 (the last of whom died in office). This may be most significant. There are now 4 trustees less than 60 years of age.

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[1] Editorial: M. Ann. District of Columbia, 1944, 13, 344.

[2] Editorial: M. Ann. District of Columbia, 1945, 14, 414.

The average age of members of the Council on Medical Service and Public Relations is now 60.3 (last year average age 58.7.) This change was chiefly due to the election of Dr. John H. Fitzgibbon of Portland, Oregon, to the Board of Trustees, thus removing from this Council its youngest member. However, the Council, as now constituted, has 6 of its 10 members aged 58 or under.

If and when in 1946 the office of Secretary and General Manager of the Association changes hands, the then 72-year-old Dr. Olin West will be succeeded by Major General George F. Lull, who in 1946 will attain the age of 59.

AGES OF OFFICIALS OF THE AMERICAN MEDICAL ASSOCIATION

	1944–45	*Age at 1944 Birthday*	*1945–46*	*Age at 1945 Birthday*
OFFICERS				
President	Kretschmer, H. L.	65	Lee, R. I.	64
President-elect	Lee, R. I.	63	Shoulders, H. H.	59
Vice President	Seeger, S. J.	57	Molony, W. R.	66
Secretary and General Manager	West, O.	70	West, O.	71
Treasurer	Moore, J. J.	58	Moore, J. J.	59
Speaker, House of Delegates	Shoulders, H. H.	58	Fouts, R. W.	60
Vice Speaker, House of Delegates	Fouts, R. W.	59	Borzell, F. F.	63
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	Irons, E. E.	67	Irons, E. E.	68
	Bauer, L. H.	56	Bauer, L. H.	57
	Henderson, E. L.	59	Henderson, E. L.	60
Average Age, Board of Trustees		63.1		60.4+
COUNCIL ON MEDICAL SERVICE AND PUBLIC RELATIONS	Adson, A. W.	57	Adson, A. W.	58
	Leathers, W. S.*			
	Brooksher, W. R.	50	Martin, W. B.	57
	McCormick, E. J.	53	McCormick, E. J. (Chm.)	54
	McGoldrick, T. A.	70	McGoldrick, T. A.	71
	Fitzgibbon, J. H. (Chm.)	50	Zech, R.	53
	McVay, J. R.	53	McVay, J. R.	54
	Paullin, J. E.	63	Paullin, J. E.	64
	Kretschmer, H. L.	65	Lee, R. I.	64
	Bauer, L. H.	56	Bauer, L. H.	57
	West, O.	70	West, O.	71
Average Age, Council on Medical Service and Public Relations		58.7		60.3

† Died in office.

* Resigned.

At least 2 or 3 principal speakers at the meeting of the House of Delegates took account of the need for youth in the affairs of national, state, and local societies. The President, Dr. Roger I. Lee, modestly proclaimed himself one of the elder statesmen who should give place to younger men.

Furthermore, it is quite apparent that returning veteran physicians are demanding and getting more places in activities, and this trend will continue. One of the reasons for this awakened interest derives from the opportunity they have had, for a time, to look objectively at the practice of medicine and to make a critical analysis of the present system of practice from a different angle.

An age analysis following the San Francisco meeting next July may be revealing.

H. P. R.

VENEREAL DISEASE CASES MUST BE REPORTED

Recently, the physicians of the District of Columbia have been publicly taken to task for their alleged failure to report cases of venereal disease to the local Health Department. Statistically, this is difficult to affirm or deny; nevertheless, the public has been given the implication that the medical profession has been negligent in performing this obligation.

An unhealthy reaction toward the profession has resulted. The impression is gained that the control of venereal disease has been hampered by such failure on its part to discharge its duties. If the profession has failed to report promptly the cases of venereal disease as they come under observation, then it is guilty of failure to abide by the law.

Section II: The Communicable Disease Regulations for the District of Columbia, published by the Health Department in 1940, authorized under an Act of the 76th Congress, reads as follows: (a) "It shall be the duty of persons in charge of hospitals, institutions, dispensaries, and public and private bacteriological, pathological and X-ray laboratories, and of physicians, parents, guardians, and other persons in charge of, or making an examination in connection with persons affected with or suspected of having a communicable disease, or communicable disease carrier to report within 24 hours the existence of such communicable or suspected communicable disease, or communicable disease carrier, and the name and address of the physician who referred the patient or transmitted the specimen for examination, except in the case of chancroid, gonococcal infections, and syphilis the name of the person affected may be referred to by number. Whenever a physician elects to report by number instead of by name, he shall be required to keep a record of the case in question in his files under a corresponding number."

This is the law; we are legally and ethically committed to it. We have no recourse under the law if we fail to observe it. We feel confident that the members of the local medical profession will review these regulations in order that they may diligently observe them.

R. Lomax Wells, M.D.
Chairman, Committee on Public Health

THE NEW COMPENSATION FEE SCHEDULE

The Society has long needed a more adequate and up-to-date fee schedule to use as a guide in determining the proper charges to be made for medical and surgical services in workmen's compensation cases. The last such Society schedule is now over 10 years old. The task of compiling a new schedule was given the Committee on Industrial Medicine during the summer just past.

The Committee promptly went to work and after a number of meetings and numerous consultations with groups of specialists has now completed a schedule which it is hoped may be found satisfactory to the Society and may be helpful to those engaged in compensation practice. The fee schedule of the Compensation Commission of the State of New York, one of the most comprehensive schedules of this kind in effect, was used as a guide, but naturally fees for some items had to be changed, some upward, some downward, in order to agree with the fees usually charged for such services in the District of Columbia.

Upon completion of the new schedule, it was submitted to the Washington Claim Men's Association in order to obtain the Association's reaction to the schedule and to be sure that it met with the approval of the Association. Following several conferences with the officers of the Association, the schedule was approved by them.

A copy of the schedule has now been sent to each member of the Society in order that all may be informed and that those who are interested may examine it and express their approval or disapproval. If it meets with sufficient approval, it is presumed that it will be adopted by the Society and be used as a guide for its members in making charges for their services in compensation cases.

A few suggestions have been made to aid those doing compensation work in understanding some of the provisions of the law and to assist them in performing their full duty, not only to the patient but to the employer and to the insurance carrier as well. It is not only becoming, it is also most proper that the physician should cooperate in every way with the other parties interested in such transactions.

W. C. M.

In and Out of Focus

BY THE OBSERVER

“. . . Only in Sophisticated Medical Climates . . .”

Your Observer has talked with many returning service physicians since the close of the war. He has enjoyed these visits immensely. For nearly all have had interesting experiences which they are not usually reluctant to discuss. Eventually, the discussion turns to plans for the future. Where to establish a practice? What must I do to get going? For there are innumerable details to be attended to upon return to civilian life. Not a few have indicated their desire to specialize. Several have said they intend to seek training in psychiatry. Your Observer is under the impression that there is a growing interest in this field, stimulated in large part by the war.

If this impression is correct, it should be encouraging news to Dr. Wendell Muncie of Johns Hopkins Hospital. Dr. Muncie recently made a state-wide tour of West Virginia with the apparent objective of determining the interest in and the adequacy of psychiatric service in that state. What he learned did not please him at all. In an article entitled, “Is Psychiatry a Medical Luxury?” appearing in the *West Virginia Medical Journal* for December 1945, Dr. Muncie writes:

> “Medicine traditionally has busied itself largely with four major drives: (1) saving life, (2) easing pain, (3) correcting deficiency, and (4) custodial care of the incurable.”
>
> The first three fields, Dr. Muncie states, “cover the bulk of medical practice and so of medical practitioners,

and on the whole the practitioners have been content with these goals.

"Psychiatry has little part in these aspects of medicine. We relatively rarely are called on to save life, the main exception being in cases with suicidal risk—a matter about which medical practitioners generally have an astonishing fatalism.

"We rarely are called on to ease pain, although experience has shown that in many instances our remedies may be much more potent than are those of the general practitioner. But only in sophisticated medical climates do we get opportunity to demonstrate our abilities. We don't deal very extensively with remedying deficiencies. Our excursions into such fields have brought meager results.

"Considering all these facts, it is small wonder that physicians and laymen alike count us as something apart, out of the usual medical field."

Dr. Muncie observes that all physicians practice psychiatry in one form or another. "Every practitioner," he says, "spends much time giving advice concerning what might be called a proper hygiene of living.

"Despite this, there remains a certain tendency to glorify the first four goals above, as being the real science of medicine, and to soft-pedal the last named as somehow inferior, and more related to the art of medicine—that vague term used to define the capacity of putting science to work in the most pleasant and effective manner. The most likely reason for this is that the victims in the last category are not very 'sick.' Many physicians and nurses are most unhappy working with people who are not very sick, in the traditional sense. The feeling of providing the deciding factors for recovery is a deep seated need in such medical personnel.

"In dealing with personal problems physicians rely heavily on their knowledge of themselves and of their common sense deductions from their practice, and as is the case with ministers, lawyers, educators, often enough give sound advice. There is a certain dependability to be expected from statistical fact, and from impressionism well grounded in experience.

"It is with these patients that modern psychiatry, an extramural and actively practicing psychiatry, claims a special position. This claim rests on the demonstrable fact that health and happiness are to a large extent equivalent phrases, that health and happiness or their opposites are historical items, with antecedents of a sort not adequately appreciated or understood outside psychiatric circles, and with measurable projective tendencies into the future.

"Speaking concretely, psychiatry has been able to specify more accurately the precursors to health and disease. These emerge as developmental, and experimental factors, largely of an emotional sort, having to do with deep seated drives, tendencies, attitudes, expressed 'outwardly' as interpersonal relations and other observed activity, or 'inwardly' in visceral functioning, in states of well being or their opposite, and in the functioning of the essential bodily rhythms.

"There is a prodigious amount of human suffering from such obscure or vague complaints as insomnia, headache, tiredness, moodiness, sensitiveness, emotional frustrations, sexual incompatibilities and dissatisfactions, gastrointestinal unrest, and anxiety states in general."

Dr. Muncie is especially perturbed because of the lack of psychiatric service in smaller communities. In his tour of West Virginia he encountered only one psychiatrist "who was living in the community and was in daily contact with his colleagues.

"The blame for this deplorable condition must rest largely on the deficiencies in medical education, which still stresses life-saving and pain-killing. Fullness of living is badly neglected by general medicine, and academic psychiatry has too often surrounded it with such a thick fog of terminology and theoretical hocus-pocus as to discourage all but the few students who, largely for personal reasons, refuse to be daunted, and insist on finding out the facts. As a consequence the annual accession of new practitioners of psychiatry is indeed small, and these few tend quite naturally to settle in large medical centers where their influence may best be exerted.

"But the whole blame does not rest there. A goodly share must rest with the medical practitioners in the smaller cities and towns, whose vision of what medicine can do is likewise limited to life-saving and pain-killing. Or if they sense that these goals are inadequate they are apt to classify the further extension of medical goals in the direction of the fuller life as a variety of luxury service, which the public will not tolerate (i.e., pay for). I do not believe for an instant that this is a correct appraisal of the public temper. The money, gladly and foolishly spent on vacations and rest cures alone, prescribed by physicians for all sorts of personal maladjustments, testifies to the public willingness to do anything to achieve the fuller life. As a matter of fact often enough psychiatric help will be found to be saving of the patient's resources, to say nothing of his bodily integrity.

"My suspicion is that there is a disinterestedness manifested in the lack of proper psychiatric care which would never be tolerated in the case of a lack of surgical care, or of gynecological care."

The solution to this problem, Dr. Muncie concludes, "rests on the clear realization on the part of the medical practitioner that psychiatry is not a luxury service, but an essential service of which suffering humanity has too long been deprived."

★

"... on Sturdy Shoulders"

Those who have attended meetings of the House of Delegates of the American Medical Association have become familiar with the sturdy figure of the gray, balding Speaker of the House, Dr. Harrison H. Shoulders of Tennessee. He has long been an able presiding officer, wielding his gavel firmly over a House which, at times, has not been too ruly. His elevation to the office of President-elect of the A. M. A. at the last meeting of the House met with the hearty approval of the delegates, many of whom have a deep affection for him.

Dr. Shoulders will be an eloquent spokesman for organized medicine. He is in many respects more liberal than most of his contemporaries. As active head of the Association in 1946–47, he will serve in what will undoubtedly be a very critical period in the Association's history.

Dr. Shoulders is not only highly thought of by his medical colleagues but also by the people of Nashville, Tennessee, where he has long resided. The *Nashville Tennessean* editorialized on December 7 as follows:

> "The Tennessean's rise to prominence in medical circles began with his return from overseas service with the army medical corps in World War I. He otherwise has been connected with public health work as secretary and executive officer of the State Department of Health and at a later date as president of Nashville General Hospital. In private practice in Nashville since 1921, he has earned wide note and respect.
>
> "Under rising social pressure, the AMA still is seeking an answer to the health needs of the American people. Its president-elect will have the opportunity as well as the task of leading his organized profession toward a happy solution of the problem, which will insure the widest possible benefit of the preventive and remedial discoveries that continually enrich the medical knowledge of the race."

Another paper, the *Nashville Banner*, comments:

> "Dr. Shoulders has earned the faith of his vast constituency, not only for professional skill, but for vision incorporating those standards and principles of medical freedom enabling American medicine to forge ahead in a field of science whose boundaries must remain beyond the reach of government dictation. As such a leader, his opinion will bear weight with the people. In this fight, his service again is to his country, no less than when he wore his country's uniform against another, external enemy."

★

Change Comes to the A. M. A.

The question uppermost in your Observer's mind last November was, "Has Change Come to the A. M. A.?" He had high hopes following his participation in the Public Relations Conference sponsored by the A. M. A.'s Council on Medical Service and Public Relations at Chicago in October. There had been a unanimity of opinion that the Association must sponsor an adequate national health program. However, the Conference could merely recommend, and the final decision rested with the Association's House of Delegates, which was to meet in December.

Late in November, President Truman's health message aroused the medical profession to the need for prompt and vigorous action. What should be done? As usual, there was a protest against "political medicine" from the Association's headquarters in Chicago, but medical leaders well knew that protests were not sufficient.

It was under these conditions that the House of Delegates met in Chicago on December 3. Your Observer felt quite certain that with the hot breath of the Administration down its neck, the official body of the Association would act. But still he was apprehensive. The delegates might possibly dodge the issue. He observed with interest the complexion of the House. He saw many old-timers who had been in attendance ever since he could remember. There were some new, youthful faces. A few of these demonstrated qualities of real leadership before the meeting was over. This was most encouraging, but the old-timers still ran the show.

At few meetings of the House had there been so many resolutions introduced. In fact, they were so numerous that reference committees worked day and night. Obviously this was no ordinary meeting, delegates being intent on the serious business at hand.

On the closing day, the weary delegates finally came to grips with the most important issue before the meeting, that is, what type of health program should be adopted. For the House was in general agreement that a negative position was no longer tenable. Something constructive had to be done, and that on a nation-wide scale.

A day or two before sessions of the House opened, the Conference on Voluntary Prepayment Medical Care Plans, sponsored by the Council on Medical Service and Public Relations, had been held. The Conference had voted unanimously to present to the House the following resolution:

> "Whereas, voluntary prepaid medical care programs, sponsored and operated by the medical profession in many parts of the country, are providing the means whereby millions of persons are able to obtain good medical care and hospital service on a budgeted basis; and
>
> "Whereas, this medical care has been rendered in a manner highly satisfactory to both patient and physician, and
>
> "Whereas, there are forty-seven voluntary plans in operation in twenty-four states, with almost every other state medical society in the process of developing plans, and
>
> "Whereas, in spite of this development some areas of the country have no such programs in operation at the present time; and
>
> "Whereas, these voluntary prepayment plans are based on the intrinsic American principles of personal initiative and personal responsibility, and
>
> "Whereas, the voluntary type of prepayment plan is to be preferred—in the interest of the people's health—to compulsory care under political control, and
>
> "Whereas, a large proportion of the people desire prepayment medical care programs, therefore be it
>
> "Resolved, that the House of Delegates take immediate steps to encourage the development of a national voluntary prepayment medical care plan:
>
> "For the purpose of covering areas not now served by plans;
>
> "For the purpose of assisting in the enrollment in local plans of national enrollment groups, and
>
> "To serve until such time as all states have their own plans.
>
> "Resolved, that the American Medical Association's Council on Medical Service and Public Relations be instructed by the House of Delegates to take immediate steps to:
>
> 1. Coördinate the activities of all prepayment medical care plans now in operation.
> 2. Foster the development of such plans in those areas where there are none.
> 3. Educate physicians and the public as to the functions of voluntary prepayment plans and the need for supporting them.
>
> "And be it further
>
> "Resolved, that the officers and committees of every State Medical Society be urged by the House of Delegates to secure prompt action by their State Society in inaugurating new, or increasing the benefits of existing prepayment medical care programs in every state."

When the House convened this resolution was referred with several others to the Reference Committee on Legislation and Public Relations. It was at this point that our Society began to figure in the proceedings.

The Society had long ago approved prepaid medicine. Despite its ill-fated experience with Mutual Health Service, it had reiterated its belief in the desirability of a further experimentation with prepayment plans. It had consistently favored constructive action by organized medicine on a national level. In line with this attitude, the Society's Delegate, Dr. Coursen B. Conklin, upon request of the Executive Board, introduced the following resolution:

> "Whereas, the Medical Society of the District of Columbia has long favored the adoption of a constructive program by the American Medical Association where social and economic issues relating to medicine are concerned;

"WHEREAS, in recent months there have been encouraging signs of positive action by the Association's Council on Medical Service and Public Relations; and

"WHEREAS, in the opinion of the Medical Society of the District of Columbia efforts should be continued to project a program which will receive wide public support,

"BE IT THEREFORE RESOLVED that the House of Delegates of the American Medical Association instruct its Council on Medical Service and Public Relations to proceed as promptly as possible with the development of a specific national health program, with emphasis upon the nation-wide organization of locally administered prepayment medical plans sponsored by medical societies, to be submitted to the House at its meeting in June, 1946, for its consideration."

In addition to Dr. Conklin, representatives of the Society appearing before the Reference Committee in support of this and similar resolutions were Dr. William Earl Clark, President of the Society, and Dr. Herbert P. Ramsey. The report finally submitted by the Committee and adopted by the House follows:

"Your Reference Committee has reviewed several resolutions calling for the adoption of voluntary prepayment medical care plans.

"All of these plans show a uniformity of desire for the immediate setting up of a national plan on a voluntary basis. In all of them the urgency of this being done is stressed.

"Accordingly, the Committee recommends that the House of Delegates of the American Medical Association instruct its Board of Trustees and the Council on Medical Service and Public Relations to proceed as promptly as possible with the development of a specific national health program, with emphasis upon the nationwide organization of locally administered prepayment medical plans sponsored by medical societies."

As will be noted, recommendations contained in the above report are identical with those in the resolution introduced by Dr. Conklin. In fact, the phraseology of the Society's resolution following "Be It Therefore Resolved" was incorporated verbatim in the Committee's report. Only the final phrase "to be submitted to the House, etc." was deleted and the following words "instruct its Board of Trustees and" were inserted. Thus our Society has written a footnote in history.

It is perhaps to be expected that the public generally, and even those whom one thinks of as being informed about such matters, does not appreciate the significance of the House's action. As a matter of fact, newspaper editors who had long belabored the A. M. A. for failing to offer a constructive program did not comprehend what had taken place. There is no doubt about it, history was made on the morning of December 5. For on that day organized medicine committed itself to a step which, if carried out, will vitally affect the lives of all the people of this country.

In recent years our Society has shown itself both progressive and realistic where current medical issues are concerned. Your Observer was proud of the Society's part in this history-making session of the House.

In view of the House's action, it is up to the Board of Trustees and the Council on Medical Service and Public Relations to proceed immediately with the task assigned to them. Vigorous and prompt action is essential. The time is late—very, very late.

★

Washington Press Comments on President's Health Message

Physicians in the Nation's Capital are understandably sensitive to the reaction of Washington newspapers where matters of health are concerned. In a large measure this is due to their proximity to Congress, which in recent years has had considerable controversial health legislation before it, and the resultant newspaper stories and editorial comment, much of which has not been too favorable.

Naturally, then, the medical profession awaited without too much optimism press comments on President Truman's recent health message to Congress. As it turned out, not only did every newspaper have its say editorially, but commentators, too, took a hand. The result was not too happy for organized medicine. But let these writers, both anonymous and otherwise, speak for themselves.

The following excerpts are those your Observer considers the most significant.

Lowell Mellett—"On the Other Hand," *The Evening Star*, November 22, 1945.

"Physicians are members of a proud profession and some of them won't like to see this said, but it is the fact that President Truman's national health insurance plan, presented to Congress this week, could almost be called a bill for the relief of doctors."

"Most of the opposition to such bills in the past has purported to be in defense of the doctors. Conservative legislators have chanted the sinister word, 'socialization!' whenever a proposal has been offered to extend medical care to all parts of the population. Some medical organizations have joined in the chant. The inference has been that any such undertaking would 'socialize' the doctors and do them great damage.

"How truly these legislators and medical associations represent the average doctor, or the majority of all doctors, cannot be estimated. But it can readily be shown that they do not represent the average doctor's financial interest."

Editorial, "The President on Health," *The Evening Star*, November 23, 1945.

"Unquestionably numerous objections can be raised against such a program on the ground that it might involve great administrative difficulties, be much too costly, or open the way to socialized medicine. These objections, in fact, have already been made, with some medical circles taking a particularly emphatic stand against what they regard as the threat of socialization. President Truman, however, argues persuasively to the contrary, insisting that his proposals would, with other things, not only attract doctors to regions where they are not now sufficiently available but would also be economically beneficial to the profession as a whole, with everybody's bills prepaid by the insurance.

"The proposed program is far-reaching, of course, and Congress may find reason to make fundamental changes in it, but to oppose it—by calling it 'socialistic,' for instance—without offering a constructive alternative is pointless. This promises no solution to a very real national problem—a problem which, in the absence of an adequate alternative, will surely be dealt with through some such program as the President advocates."

Ernest Lindley—"Health Insurance," *The Washington Post*, November 23, 1945.

"Insurance against the costs of medical care is, in some ways, a more complicated problem. Most of the organized medical profession is against it. The familiar cry of 'socialized medicine' has been raised again by the American Medical Association.

"What the President proposed is, of course, not socialized medicine. . . .

"The accusation that this is 'socialized medicine' is so far removed from the fact that it does not do justice to the legitimate questions or objections of the medical profession or of many consumers of medical care. Having so little relationship to the facts, the slogan is a poor one with which to rally support for the medical opposition to insurance against the cost of medical care. It is almost an insult to the intelligence of the ordinary citizen.

"There probably will be a great deal more discussion and debate—perhaps several years of it—before insurance against the cost of medical care is adopted. This problem, like other plans for expanding the social insurance program, deserves to be considered on its merits. The President's clear and moderate statements contributed to that end."

Editorial, "Medical Insurance," *The Washington Post*, December 6, 1945.

". . . 'when we consider the economic status of those who now have such protection and of those who do not have it—but do experience more frequent and serious illnesses—it becomes all the more evident that voluntary insurance is not a complete or adequate answer to this national problem of spreading the costs of medical care.'

"This seems to us to be the nub of the matter. The element of compulsion in the President's program is nothing more than a method of spreading the cost equitably. Health, like education, is a national concern. It needs to be fostered through the united effort of the whole American people."

Mark Sullivan—"$64 Question in Plan for National Health Is 'Who Pays Doctor?,'" *The Washington Post*, December 9, 1945.

"About the lack of sufficient medical care, especially in some parts of the country, there is no question. But about the President's national health program as a remedy, especially about details of it, there will be much debate. It has already begun.

"Physicians, as represented by the American Medical Association, are justly proud of the profession's extremely high standards of medical skill and training and medical ethics. They fear that Government participation in the field of medicine might bring substitution of standards set by Government officials.

"They fear that Government may interfere in the relations between doctors and patients; that Government may dictate to doctors about whom they may have for patients and dictate to patients about what doctors may treat them. They fear the practice of medicine may be put on a socialistic basis."

"The President's health program can become socialized medicine or remain free. Which turn it takes depends on how the measure is written, after debate in Congress, and how the system is administered.

"One test will be how and to whom the Government pays the money for health insurance. In Social Security the Government pays direct to the beneficiary, and he uses it as he freely chooses. If in health insurance, likewise, the Government pays direct to the beneficiary, the beneficiary will be free to choose his own doctor, and doctors will have no cause for complaint in that respect. But if the Government is to make the payments to doctors, Government would in that case choose the doctors, or set up categories of doctors acceptable to it. It would have much control over doctors, their fees, their standards of practice and their relations with patients. And with control over doctors would go control over patients.

"By watching this and other tests, Congress, in writing the details of the measure, can achieve the benefits of health insurance without the dangers which doctors and others fear."

FRANK C. WALDROP—"Doctors' Bills," *Times-Herald*, November 21, 1945.

"Many medical societies, including that for the District of Columbia, have set up plans for people who know how to plan and are willing to prepare against health breakdowns. But all these put together are small-scale stuff, compared with the national need. Just consider this as evidence: As of April 1, 1945, nearly 5,000,000 American men between 18 and 37, registered in the draft, were found unfit for military service. Of all examined, about 30 per cent were found physically incapable of soldiering.

"It ran higher, naturally, as the age level increased—49 per cent of the men between 34 and 37.

"And we are a nation with a steadily increasing average age level. No longer is the United States the most vigorously youthful land in the world.

"As a people we're getting on toward middle age and we have to act accordingly. Truman has a plan to meet the doctor's bills. It is a good one. Let's not be led away from it by labels."

EDITORIAL, "National Health Insurance," *The Washington Daily News*, November 20, 1945.

"Anticipating the stock objections, Mr. Truman insists that what he proposes is not socialized medicine and would not mean Federal control of the medical profession. Patients would be free, he says, to choose their own doctors and hospitals, and to obtain medical services in addition to those provided. Doctors would be free to accept or reject patients, to decide what services patients need, or to practice partly or wholly outside the insurance system. And the system would be highly decentralized, with local administrative units as its keynotes.

"On the average, the President estimates, the American people spend 4 per cent of their incomes for medical and hospital care. He believes that the insurance program would need total amounts about equal to 4 per cent of their earnings up to $3600 a year. How much of these amounts should be collected in premiums, and how much contributed by the Government, is a matter for Congress to decide, he says.

"Correct. Up to Congress, also, are the other points in Mr. Truman's program. These include Federal aid for construction of hospitals and health centers; Federal aid in expanding public health, maternal and child health services; Federal support for professional education and medical research; Federal disability insurance against loss of wages because of illness.

"None of these proposals is new. They have been before Congress for a long time, in various versions of legislation sponsored by Sens. Wagner and Murray, Rep. Dingell and others. Promptly in order now, we believe, is a comprehensive public hearing on them, giving the people fullest possible opportunity to understand what is advocated and what contrary arguments may be advanced.

"And we aren't trying to be facetious when we add that consideration of these and all other proposals involving Government spending should take due account of the health of the Federal Treasury. Some sort of insurance against a continued decline into deeper and deeper debt is urgently needed there."

★

A Californian Speaks His Mind

Few in attendance at the last session of the House of Delegates of the A. M. A. will disagree with the observation that the California delegation revealed themselves an unusually able group of men. Whether or not one concurred in the views they expressed, no one could deny that their spokesmen were forceful, even eloquent.

Dr. Philip K. Gilman, President of the California Medical Association, who described himself as one of the "older fellows," made one of the most forthright addresses before the Conference of State Medical Society Officers, held immediately prior to the meeting of the House, it has been your Observer's privilege to listen to in a long time.

Dr. Gilman reminded his listeners of the C. M. A.'s struggle against the enactment of compulsory health legislation in California. He said the situation had been much more serious than the physicians outside of the state realized, and cautioned the medical profession not to take health legislation recently introduced into Congress lightly.

"Just what is behind this new Wagner-Murray-Dingell bill? Why has the President come out in favor of this program?," Dr. Gilman asked. "These questions should be uppermost in our minds because only by knowing why the other fellow is aiming his dart in our direction can we hope to defend ourselves against his attack.

"If we consider these questions for a moment we must come at once to the realization that the whole question is bound up in the fundamentals of medical economics, particularly that portion of this subject which deals with the distribution of medical care and auxiliary services. We must freely admit among ourselves that there is an uneven distribution of medical care. Some of our states enjoy four, six or ten times the amount of medical service that other states have. Some of our states have six, eight or ten times the hospital beds on a per capita basis that other states have. Even within the boundaries of our own state, some of our counties are relatively surfeited with medical service while others are starved for it. Among the various levels of our society, we all know that some groups, some income levels, enjoy adequate medical service while other groups suffer from a lack of the same service. We look around and see our splendid teaching institutions and our modern hospitals—and at the same time we see people who cannot find ready access to these facilities because of the financial barrier raised between the patient on the one side and the doctor and his appurtenances on the other. In the face of these obvious facts we must recognize the problems of medical economics raised in proposals such as those the President has just made.

"Our problem—and our only problem—is to see that these medical economic questions are adequately answered in such a manner that the best elements of medical science and medical practice are maintained. We must see to it that the *quality* of medical care does not suffer in an effort to increase the *quantity* or the *availability*."

Dr. Gilman had visited several cities for the purpose of obtaining data. "From a study of this information," he said, "it is perfectly clear that the success of medically-sponsored prepayment plans runs in direct proportion with the willingness of the medical profession to assume responsibility for the provision of medical service to the public on a budget prepayment basis. Where the profession has assumed this responsibility the prepayment plans have prospered and the public has been well served. Where the profession has ducked the responsibility completely—or has turned it over to the other fellow—these plans have had a mediocre growth at best.

"It has always struck me as somewhat paradoxical that our profession is more than willing to assume complete responsibility for the care of the indigent but has persisted in dodging that responsibility so long as the patient has a dollar or two in his pocket. In my opinion, we as a profession must assume a joint responsibility for the medical care needs of the entire population, regardless of income status. We must take care of the middle and low-income groups just as readily as we treat the charity cases in our county hospitals.

"The world has changed during our lifetimes. New economics have entered the picture, social security has become a byword and an accepted fact. It is up to us to gear ourselves and our practices into it. It is up to us to make those changes in the economics of medicine which are demanded by the times and by the people living in these times.

"Again risking the charge of being provincial, let me point out to you that in California we have faced the threat of state medicine almost constantly for the past seven years. We have met that threat by undertaking to provide for the people of California a prepayment plan which we hope will have enough public appeal to be extended to so many people that there will be comparatively few of our citizens left to demand state medicine. If we had been able to move faster—and I will be the first to admit that our prepayment system has had and still has its faults—if we had been able to move faster and cover more people, we would not have had the really dangerous threat which faced us and caused us so much work this year."

Dr. Gilman warned that no prepayment plan will succeed unless the profession is thoroughly organized. He mentioned the mushroom growth of the National Physician's Committee, the United Public Health League, and the Association of American Physicians and Surgeons. Critical of the Council on Medical Service and Public Relations, he admitted that this body could be of the greatest value to organized medicine. But, he observed, it must have prestige and authority.

"As to the men it needs, two things are vital," he said. "First, we must select our men not on the basis of the degrees which they may string behind their names but on the basis of what they know, whom they know and what they can accomplish. We should spare nothing in selecting the men—we need men who can accomplish what we need and we must pay them whatever is necessary. No academic degrees are necessary—no salary is too high. We need real accomplishment. Second, we need young men. Not college sophomores but young men of brains and judgment with the flexibility and the vigor of youth. Too many times I have seen—and I know you have, too—our medical organizations operated by men too mature in years to have the punch needed in the pinches. I have been urged in my own state to continue in the administrative end of our state medical association, but I am too far advanced in years to carry on the active work that we need. There are plenty of younger men in the offing who can deliver a harder blow when it is needed and who have the brain power and judgment that we older fellows like to think we possess. There is no patent on brains and judgment but there is a definite limitation on the drive that we older men can put into an aggressive campaign. We need more youth, more vigor, more punch. The very physical beating that some of our men in California took for six months this year in fighting state medicine has proved to me that age must be recognized as a barrier if we are to fight the larger battle now being prepared in Washington."

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Traffic Congestion Handicaps Doctors

"With the rationing of gasoline a historical event, the streets are again swarming with automobiles. Even with all parking and driving regulations strictly obeyed the congestion in the central city streets would be terrific. To make matters far worse there is a laxness in the motorists' observance of regulations and the enforcement of them by the police that is rapidly making travelling through Philadelphia by motor car an impossibility."

Thus the Editor of *Philadelphia Medicine* in the November 24 issue describes the traffic situation in the Quaker City. Your Observer sympathizes with his neighbors because he had long since come to the conclusion that no city could match Washington for traffic congestion. Parking in the downtown area of the Nation's Capital during the day is virtually an impossibility. Traffic regulations are openly flaunted because the police force is not large enough to cope with transgressors. Most common violations are passing through red lights, turning from the wrong lane, and speeding.

Apparently the situation in Philadelphia is equally bad, if not worse, and has seriously handicapped physicians. "As physicians," the Editor comments, "we are very interested that our streets be kept free from unnecessary congestion. Some of our large hospitals are in the congested area and it is often essential that we reach them without delay. Often, too, we must traverse the central city streets to reach patients in their homes or at hotels and sometimes these are urgent calls. It is true that the occasions are not frequent when ordinary delays will cost a life but such occasions do occur and lives are too high a cost to pay for the laziness of motorists who will not leave their cars in the proper places. Even the increased fire hazard from parking on the left side of one-way streets, obstructing as it does the city's fire fighting apparatus, is too high a price for such laziness.

"Yes, physicians are interested parties in keeping the streets free from unnecessary congestion but some of them are among the offenders. Unfortunately for the entire profession it is not unusual to see cars bearing medical emblems parked on the left side of our one-way streets. Perhaps in these cases the doctor has stopped at his office for just a moment to pick up an instrument but a telephone call must be answered or an unexpected patient stretches the moment into ten minutes or even into a half hour or more. The solicitor of the Physicians' Motor Club recently remarked that so much could be done for physicians involved in motor vehicle cases because physicians have such a high reputation with the police for obeying the law. How long can such a reputation remain unsullied if even a small group in our profession are flagrant violators!

"Of course, the present widespread ignoring of motor vehicle regulations and laws is pretty largely the fault of our police authorities. No one will park on the left side of one-way streets, park in restricted areas, or do the many other things that cause unnecessary congestion if there is absolute certainty that such violation will cost a fine and that persistent violations will cost the offender the right to drive an automobile. Our laws and police regulations should be strictly enforced without regard to who the individual may be who gets caught. However, until they are, we as physicians should set an example for others to fellow."

In some respects Washington physicians, despite traffic conditions, are more fortunate than their Philadelphia colleagues. Many months ago, at the Medical Society's request, the District's Department of Vehicles and Traffic and the Metropolitan Police Department agreed to extend special parking privileges to physicians. Doctors may now park in otherwise restricted zones when on emergency calls providing they display cards on their windshields bearing their names and the Society's seal. This plan has worked successfully, largely due to the fact that physicians have played fair. Very few have taken advantage of the privilege.

With respect to the hospital parking situation, that is not as bad as it might be because most institutions have nearby parking lots. However, when they are filled, it becomes a problem for the doctors because nearly every foot of available parking space in the downtown and even the uptown area is occupied throughout the twenty-four hour period. It is quite evident that something will have to be done, and soon, about the parking situation in the District of Columbia.

There will undoubtedly be an improvement in the enforcement of traffic regulations as soon as the manpower situation eases a bit. Washington should be generous in expending funds for the employment of additional traffic officers. For this will do much to reduce the number of deaths and injuries due to automobile accidents. Incidentally, driving in the District would also be a less harrowing experience.

All in all, it is your Observer's belief that Washington has fared well enough in the emergency considering the overcrowded conditions which, despite the war's end, still exist. He is confident that before many months the situation will improve.

Again your Observer sympathizes with the Philadelphia physicians and wishes them better going in 1946.

An Estimate of Dr. Fishbein

Long spokesman for the American Medical Association, Dr. Morris Fishbein is without doubt the most widely discussed figure in medicine today. As might be expected, he possesses a forceful personality, one which is not readily ignored. In any group he is usually the center of attention. Whether one likes Dr. Fishbein or not, and, of course, he has his staunch supporters as well as detractors, all agree that as an editor he is in a class by himself. In fact, it is taken for granted that in this respect he will loom large in medical history.

Were he to confine himself to editing, he would undoubtedly avoid much of the criticism now levelled at him. For his opponents say it is not as the Editor of the *Journal of the American Medical Association* that they take issue with him but as spokesman for the Association. In the minds of the public, they argue, he *is* the Association. In fact, said one of his critics, "Many think he is the permanent President of the Association." Dr. Fishbein's opponents insist, too, that he does not speak for them or, for that matter, for a majority of the medical profession. They say his facetiousness, sarcasm, and wise-cracking are a decided liability rather than an asset to the A. M. A.

Now these are not necessarily your Observer's views, although he has at times disagreed with Dr. Fishbein. His criticism of him has in no sense been a personal matter. He has, as a matter of fact, had the most pleasant relations with him. So what he has to say here is written with no other purpose than to present as objectively as possible a medical leader who has long been a key figure in organized medicine.

Some of Dr. Fishbein's personal endowments have already been mentioned. They are of such a nature as to make most individuals seem very ordinary. He has a quick, incisive mind and a retentive memory. As we learn from "Tonics and Sedatives" and other sources, he is a tireless worker, an omnivorous reader, a prolific writer, and an unusually able speaker. In addition to editorial duties, he devotes himself to a variety of "outside" interests. One suspects at times that he is spreading himself too thin. For his observations are not always profound; in fact, they are at times quite superficial.

Few men are as gifted when it comes to public speaking as Dr. Fishbein. He is never at a loss for words. Quick-witted in debate, he possesses an unusual facility of expression. However, the fact that he is never at a loss for words has its disadvantages. He cannot resist the temptation to gloat over his own cleverness. This is the characteristic which is so repugnant to many who otherwise admire him. And too often it does not go down well with the public.

Dr. Fishbein's literary output is enormous although uneven in quality. One wonders how he finds the time for it. But writing and editing, as has already been made clear, are only a part of his activities. For example, when advice on medical matters is sought by newspapers, public officials and educators, Dr. Fishbein is the one to whom they invariably turn. There seems to be no doubt that he enjoys this role more than any other. One suspects that being the indispensable man is very much to his liking. In fact, he is not averse to admitting his superior qualifications in this respect. Certainly it cannot be said of Dr. Fishbein that he finds the many responsibilities placed on him onerous. On the contrary, they are so much tonic to his highly-spirited personality.

Officials of the American Medical Association have not been averse to admitting Dr. Fishbein's indispensability—the attitude taken being, where a difficult task is concerned, "Only Morris can do it." He would not be human if he did not enjoy the prestige which this confidence bestows on him. Dr. Olin West, Secretary and General Manager of the A. M. A., dislikes speaking in public whereas Dr. Fishbein loves it. Dr. West also dislikes politics and here, too, Dr. Fishbein apparently is in his element, although less successful than on the platform. There seems to be no resentment on the part of officials that Dr. Fishbein is looked upon as "the Association." In fact, one comes to believe that they encourage it. For example, those who have attended meetings of the Association's Board of Trustees are not long in learning that members of the Board have a great deal of respect for Dr. Fishbein's views.

There can be no doubt that Dr. Fishbein's comments on controversial medical issues reflect the official attitude of the governing bodies of the A. M. A., the House of Delegates and the Board of Trustees. But it is also true that his manner of stating organized medicine's case has too frequently irritated both physicians and laymen.

One can conclude from all this that Dr. Fishbein is more generously endowed mentally than his associates, a fact which they seem to have accepted without reservation. They are content to let him do pretty much as he likes. They look upon him not only as an able editor but as a "natural" where public relations is concerned. However, it is safe to say that the medical profession is not generally in agreement with A. M. A. officials on this point. At least that is the impression one gets from talking with many members of the Association. They want a change in "spokesman."

Being aware of the strong opposition to Dr. Fishbein's continuing his public relations activities, the Board of Trustees recommended to the House of Delegates at its last meeting that a survey be made of the Association's public relations program by disinterested parties. This, in the opinion of your Observer, is a wise move. For it should dispose of the controversy, which does not benefit Dr. Fishbein or the medical profession.

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"...the Art of Medicine Diminishes..."

Experiences of medical officers in the recently concluded war will be the source of discussion for years to come. The vast majority had been civilians prior to the emergency. Military life was therefore often onerous. They were particularly irked by assignments which had little to do with medicine, time which was wasted, and rigid administrative routine. As Dr. G. W. Murphy told the North Carolina Radiological Society last October, "One of the first things said to the new medical officer is: 'The Medical Department assumes that you are professionally competent, and you will now be trained to become a soldier.' From that time on he hears much of military matters, but little of medicine."

An abstract of Dr. Murphy's talk entitled, "Doctors, Take Warning!" appears in the November number of the *North Carolina Medical Journal*. It contains an appraisal of the Army medical service which will undoubtedly coincide with that of many of Dr. Murphy's colleagues. In fact, your Observer has heard similar opinions expressed on many occasions.

"The medical officer," Dr. Murphy writes, "shares with the civilian doctor the desire to succeed, but he soon learns that success comes through the operation of an entirely different group of factors. He becomes conscious of the fact that his responsibility is no longer to his patients, but to his superior officers. He becomes aware that his immediate superiors also desire to succeed and that they in turn must please their superiors. In a short time, observation shows him only too well that a handsome figure, a pleasing personality, the faculty of saying 'Yes,' a knowledge of army regulations, and some executive ability may bring success in the form of rapid promotion, but that the confidence he inspires in his patients is of very little moment. The inevitable result is that his interest in the art of medicine diminishes and his best efforts are directed along those other paths which he believes are more likely to lead to success.

"During my three years in the army, I came into contact with many physicians, and I feel that, with a very few exceptions, all of us suffered a gradual professional deterioration. We are coming back into civilian life much poorer doctors than when we were commissioned medical officers.

"This is no unreasonable indictment of the Army Medical Corps, for it has been well organized and excellently administered, and the evils mentioned would have been unavoidable in any regimented system.

"If the medical officer, inspired by a great national emergency, and responsible to superiors who were also medical officers to the highest levels, was embittered and disgusted by the lack of appreciation and utilization of his professional skill, you are asked to consider the inevitable effect of any system of governmental control of medicine in which military discipline would be lacking and in which control would be exercised by nonmedical directors and politicians. In such a system the desire to succeed would again be the motivating force, but success which resulted from pleasing a group of governmental officials would produce a vastly different type of medical service from that which comes from pleasing the individual patient."

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The Conquest of Pneumonia Few meetings held at the Medical Society's building have been more stimulating than the one held on the evening of November 28 when Dr. Russell L. Cecil, Professor of Clinical Medicine, Cornell University Medical College, New York, addressed the Society on "The Treatment of Pneumonia." The auditorium was filled to near capacity, there being more than 400 present. Keen interest in the speaker and the subject was shown by the close attention given Dr. Cecil's address and the fact that very few left before the meeting was over.

Among other things, Dr. Cecil emphasized the effectiveness of chemotherapy in the treatment of pneumonia, directing attention to the sharp reduction in mortality from this disease. In view of Dr. Cecil's discussion, special interest attaches to a report which appears in the *Statistical Bulletin* of the Metropolitan Life Insurance Company for October.

"The drastic reduction in the mortality from pneumonia in the past 15 years," the *Bulletin* states, "is one of the phenomenal achievements of modern medicine. In the decade of the 1920's, when specific therapy was still largely in the experimental stage, the age-adjusted death rates from this disease fluctuated widely around an average of about 75 per 100,000 in the experience of the Industrial policyholders of the Metropolitan Life Insurance Company (ages 1 to 74 years). Since 1930, however, the trend of the mortality . . . has been rapidly downward. For the first nine months of the current year the death rate is at the record low figure of 20 per 100,000. In the past eight years alone, mortality from pneumonia in this insurance experience has dropped more than two thirds.

"This marked improvement in mortality is the result of modern methods of treating the disease. Specific serum therapy began to come into general use in the early 1930's. It became fairly widespread toward the end of the decade, as increased quantities of the serum were manufactured and distributed, as the efficacy of the treatment was demonstrated, as increased facilities for pneumococcus typing became available, and as physicians learned the technique of administering the serum. The increasing control gained over pneumonia during the serum treatment era should not be overlooked just because this type of treatment has since been almost altogether displaced by chemotherapy. . . . The death rate from pneumonia for the greater part of the 1930's was stabilized around an average of 54 per 100,000 policyholders, as compared with an average of 75 in the previous decade. Particularly noteworthy is the sharp drop in mortality from 56.1 per 100,000 in 1937 to 40.8 per 100,000 in 1938, before the sulfa drugs were used to any appreciable extent. After the introduction of the sulfa drugs toward the close of the decade, and after the discovery of penicillin even more recently, chemotherapy has been used very widely with the splendid results already noted. . . .

"People in every age group and in both sexes have benefited enormously from the newer methods of treatment. . . . In virtually every age group from 5 to 44 years among white males, and from 5 to 64 among white females, the decline in mortality was 60 per cent or better. At no age period in either sex was the drop less than 43 per cent.

"The outlook for the conquest of pneumonia in the near future is promising. At the same time, it should be remembered that the disease is still among the major causes of death and sickness, and that no method of immunization against it has yet been discovered. Moreover, there are the so-called 'virus' or 'atypical' pneumonias which are not amenable to chemotherapy, and which took a considerable toll of life as recently as the winter of 1943–44. The attack against pneumonia must be carried on with unremitting vigor. It should be emphasized that the people themselves have a definite role to play by seeking early diagnosis and treatment."

DOCTORS SEEK SUBSTITUTE FOR U. S. HEALTH PROGRAM*

THOMAS R. HENRY

Correspondent for the Evening Star

The American Medical Association has just met squarely what many of its members believe to be the greatest challenge yet offered to independent medical practice in the United States—the far-reaching Wagner-Murray-Dingell bill, introduced following President Truman's message to Congress on national health on November 19.

This legislation in effect would set up a system of compulsory health insurance met by deductions from pay envelopes. It seeks to improve the national health by making medical service available to all the people—to spread over the population the inestimable values of medical progress over the past generation.

The organized medical profession of the United States has itself made great advances in this direction and it is aware of the hurdles and pitfalls better than any other group—for it is constantly coming in contact with them.

The Association, following instructions from its House of Delegates' meeting in Chicago last week, is hard at work on a prepayment sickness-insurance plan which, its members feel, will confer every real benefit likely to come from the national legislation now proposed, will be more practical and will keep the profession free of lay—and they fear, political—direction and interference.

FATHERED BY D. C. SOCIETY

This decision by the Medical Association is largely due to the efforts of the Medical Society of the District of Columbia, one of the most progressive groups in organized medicine, which essentially framed the resolution adopted at Chicago. It is difficult to predict the lines the national plan will follow. Proposed setups have been submitted by several State societies.

There are certain elements in the broad picture of medical care which are responsible for the greatest hardships to the individual—such as hospital

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bills, surgical bills and obstetrical bills. There are already efficient schemes of hospital insurance, largely under private auspices. Memberships are growing as the benefits are better appreciated, and there appears to be little room for change except for improvements in details. Need for major surgery is clearly a catastrophe, like a fire. Presumably, reasonably accurate statistical tables can be framed on which to base insurance costs. With those taken care of, the physicians believe, perhaps the biggest element of the problem will be solved.

There still remains a vast, uncovered field in which, it is presumed, the men at work on the national plan will proceed cautiously, by a system of trial and error, rather than by a broad application of untested ideas such as is indicated by the bill now before Congress.

Doctor Wants to Be Free

The American doctor wants to remain free. He believes that his freedom in the past has been one of the greatest factors in building up the finest medical service anywhere in the world. He believes that no discipline imposed from outside will approach in effectiveness the discipline of its own members, by organized medicine and the self-discipline of the members themselves. But also he is thoroughly devoted to the extension of the best medical service to all the people in the most effective way possible.

Both the physicians and the Government face one of the most complicated social questions imaginable. Compared to sickness insurance, such a complex problem as unemployment insurance is simple. No other field in the past has been less susceptible to socialization. It has seemed somewhat like socializing music, art or poetry. As one physician remarked: Insurance against sickness is like a newspaper insuring itself against ever being scooped.

Like every large body, the American Medical Association has its right, left and center. These are expected to work out their differences in the numerous conferences which will be necessary before a workable plan is adopted to take the place of that proposed by the Government.

Trend toward Socializing

The fight is not against "socialized medicine." This is a complete misnomer, says Dr. Roger I. Lee of Boston, newly elected President of the American Medical Association. Medicine has grown more and more "socialized" for the past century—largely through the efforts of the physicians themselves. Every public health department, every public school clinic, every State or municipal hospital, is a manifestation of "socialized medicine."

Instead, the battle is against "political medicine." There is an infinite difference between the two, Dr. Lee says. There are certain medical and public health services which can be rendered almost mechanically by any conscientious, qualified individual. Such, for examples, are general inoculations in the face of an epidemic, X-raying of the chests of school children, fortifying deficient foods with essential vitamins. Medical societies everywhere have fought for these things. They have played, perhaps, the principal part in making the American people the healthiest in the world. There could be no finer case for such work than the experience of the Army and Navy in the war. The sickness rate from communicable diseases was reduced to a point where it was almost inconsequential, although it has been one of the major problems in all past wars.

The doctors have no quarrel with the creation by society of an environment conducive to health, and both national and local societies constantly are advocating new activities. In this field medicine is an exact science. Individuals can be dealt with en masse, for one does not vary one iota from another.

Each Individual a Problem

But the chief activity of the medical profession lies in quite a different field, where sickness is a matter of reaction between the environment and the individual—where the patient is something unique in the universe. The physical and mental difficulties of such a person cannot be dealt with on any sweeping basis. Each case presents its own peculiar problem and medicine becomes both a science and an art.

There can be no question but that the cost of medical care is high. This is inherent in the practice of a combined exact science and fine art. The burden falls heaviest on persons of moderate incomes. It is an old truism that the best in medicine is shared by the very poor and the very rich. For the former, communities have provided free hospitals and the medical profession, in accordance with its ancient tradition of service, gives its best efforts for nothing. The rich, of course, can afford to pay. It has been to some extent the practice of doctors to "soak the rich" to carry on their work for the poor. This has not been very satisfactory, either to the wealthy patients or the physicians. But the family whose income just about meets ordinary living expenses often gets a terrific economic blow from unpredictable illness.

Sometimes the members struggle for years to meet the bills and seriously reduce their standards of living. Sometimes they simply do not pay. It is generally supposed, by doctors, that their bills are the last to be met. That is one of the reasons for the high cost of medicine. Those who do pay must make up for those who do not and the physician who was able to collect all his bills could cut down his charges by a big margin.

SICKNESS UNPREDICTABLE

Now the family with a moderate income can insure against other unpredictable expenses, such as fire, death of a breadwinner, etc. Why can they not insure against catastrophic sickness? One reason is that the former type of catastrophies can be predicted by exact actuarial statistics. It is a pretty safe bet that a certain number of dwelling houses in Washington will catch fire in the next six months. There is little element of guesswork in predicting how many Washingtonians in the 60-year-age group will die in 1946.

Medical practice is different. One cannot predict sickness, because there is such a large subjective element about it. Every person differs from every other person. Some demand medical services for complaints which would be regarded as inconsequential by others. Doctors sometimes make the cynical comment that the best way to cut down the sickness rate of a community is to raise prices for medical services.

Insurance against sickness costs in general, doctors say, would be unpredictably and prohibitively expensive.

Various schemes of political medicine have been tried. Perhaps the best known is the British panel system, which is not far removed in principle from that proposed in the Wagner-Murray-Dingell bill, although the latter would give a larger leeway for personal choice. A group of British physicians constitutes a panel. Each panel has a certain number of patients, who make their own free choice of the doctors on the panel. Only within this group does the patient select his own physician. Each constituent of a panel pays a stated fee each year.

DODGE RESPONSIBILITY

There are various claims as to how well this has worked. The conclusion of most American observers is that it is quite inefficient. The panel physicians are inclined to treat only the simplest of ailments. They are not held responsible for specialist service and this gives them an opportunity to avoid responsibility.

From his own observations, Dr. Lee says, the higher type of independent British physician is as good as any in the world, but the panel doctors fall far below the average American practitioners. They are much more inclined to sell medical care over the counter, like potatoes or cheese. They reach the point where the peculiarities of the individual mean nothing.

One of the greatest "political medicine" experiments was that of the Veterans Administration after the last war, when a corps of physicians was set up to care for veterans with war-connected disabilities. Over a course of years it proved a dismal failure and veterans' hospitals were a byword everywhere for inefficiency.

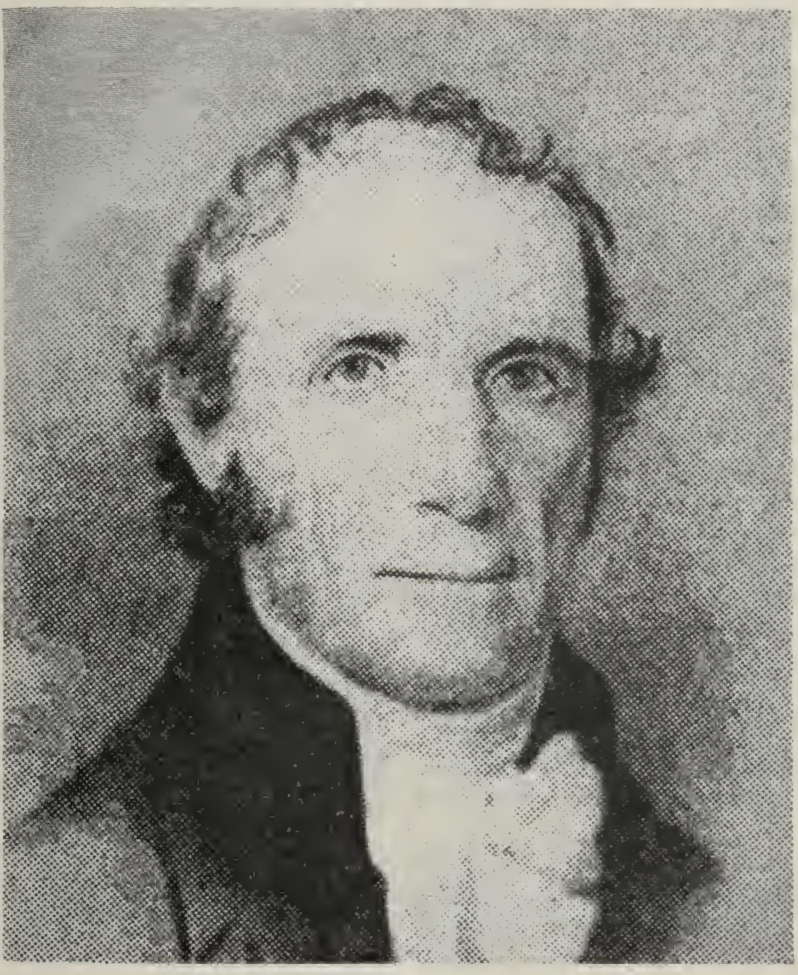
The present administration, under Maj. Gen. Paul R. Hawley, proposes to do away with this system to a very large extent and rely on the American private physician, freely chosen by the patient himself, to treat the 20,000,000 veterans of the Second World War.

HEALTHIEST IN WORLD

These 20,000,000, by the way, go a long way toward nullifying the value of any compulsory health scheme—constituting, as they do, such a considerable element of the American population. They have already the best sort of sickness insurance, for nothing. True, it is supposed to extend only to war-connected disabilities, but in actual practice the dividing line is hard to draw.

A good deal has been made of the poor health of

(*Continued on page 54*)



CHARLES WORTHINGTON, M.D.

It was said of Dr. Charles Worthington by a biographer that he and Dr. Frederick May were "the most influential medical men of the time in the District." It is not surprising, then, that Dr. Worthington was chosen the first President of the Medical Society of the District of Columbia. He was reëlected for twelve successive years, 1817–29.

Dr. Worthington, born October 8, 1759 at "Summer Hill," Anne Arundel County, Maryland, graduated from the University of Pennsylvania with the degree of Bachelor of Medicine in 1782. The year following his graduation he moved to Georgetown, then in Maryland. He lived on "Quality Hill" at the corner of Prospect and Fayette Streets. The mansion in which he lived still stands and is one of the showplaces of Georgetown.

A charter member of the Medical and Chirurgical Faculty of Maryland, he was also incorporator of the Medical Society of the District of Columbia under its first charter. He was one of the founders of St. John's Church, Georgetown, the second Episcopal Church in the District of Columbia.

Dr. Worthington, who is described as "an austere man, full of dignity and seriousness," dressed in the old style, hair *en queue*, knee breeches, long stockings, and shoe buckles. He drove a coach and four. At the time of the battle of Bladensburg and the burning of Washington, some wounded British soldiers were brought to Worthington's house. He "so won the hearts of the English by his hospitality and skillful care that one of the officers presented him with a gold snuffbox."

Dr. Worthington was married to Miss Elizabeth Booth of Jamestown, Virginia. He died September 10, 1836.

Military Affairs

WHAT RETURNING SERVICE PHYSICIANS SHOULD KNOW

Although most returning service physicians visit the Medical Society's office upon their return to private practice, some have not done so. It is not surprising that they have encountered difficulties which in some instances might have been avoided. The Secretary of the Society is very anxious to be of every assistance possible to physician-veterans. All they need to do is to call at his office or call him by telephone, District 3111.

In the hope that service physicians who, for one reason or another, do not get in touch with the Society's office can be reached through the MEDICAL ANNALS, the following information is published:

BE CERTAIN THAT YOU ARE LICENSED TO PRACTICE IN THE DISTRICT OF COLUMBIA. After many physicians entered the armed forces, the law with respect to licenses was changed. Annual registration is required. Licenses for returning service physicians can be renewed without any difficulty. Physicians should apply to the Commission on Licensure, District Health Department, 300 Indiana Avenue, N.W.

APPLICATION MUST BE MADE FOR A NARCOTICS LICENSE. Forms for this purpose can be obtained from the Society's office. Applications should be sent to the Narcotics Division, Collector of Internal Revenue, Baltimore, Maryland. Because there is often delay in handling these applications, it is suggested that the Society's office be notified when application is made. A communication will then be sent by the Society to the Commissioner of Narcotics, Washington, requesting that the application be handled promptly.

RETURNING SERVICE PHYSICIANS SHOULD NOT PRACTICE FOR EVEN A DAY WITHOUT MALPRACTICE INSURANCE COVERAGE. If a physician is a member of the Society or an applicant for membership, he is entitled to participate in the Society's group policy with the United States Fidelity and Guaranty Company. However, he must apply for an individual policy. Names of the agents who handle this insurance can be obtained by calling the Society's office.

AUTOMOBILE DRIVERS' PERMITS MUST BE RENEWED. This necessitates a personal appearance at the Department of Vehicles and Traffic where an eye test is given. In this connection, liability insurance should be taken out. This is required by law of those who live in the State of Virginia.

SERVICE PHYSICIANS WHO ARE ACTIVE MEMBERS OF THE SOCIETY ARE ENTITLED TO BE LISTED ACCORDING TO TYPE OF PRACTICE AT THE SOCIETY'S OFFICE. A classified list has been prepared for use by MEDICAL BUREAU in supplying information to the public about physicians when individuals calling do not have a family physician.

SOME TIME AGO, THE MEDICAL BUREAU COMMITTEE VOTED TO OFFER MEDICAL BUREAU'S ALTERNATE LISTING SERVICE TO MEMBERS IN THE ARMED FORCES UPON THEIR RETURN TO CIVILIAN PRACTICE FOR A PERIOD OF SIX MONTHS WITHOUT CHARGE. Members who wish to take advantage of this offer should call the BUREAU, Republic 6100.

There is other information at the Society's office of value to returning service physicians which will be provided gladly on request. The above, however, are the essential things to be remembered before the physician veteran reëstablishes his office.

GENERAL LULL TO BECOME SECRETARY OF THE A.M.A.

Major General George F. Lull, Deputy Surgeon General of the Army, whose notable record in that capacity won him the Distinguished Service Medal, the highest noncombatant award, has retired from the Army after 33 years of service with the Medical Corps.

General and Mrs. Lull will move to Chicago, where General Lull will become Secretary and General Manager of the American Medical Association. He will take up his new duties officially in July, when the retirement of Dr. Olin West, the present Secretary and General Manager, becomes effective, but he will immediately join the staff of the American Medical Association to familiarize himself with the work of the organization.

Early in World War I he commanded a base hospital at Camp Beauregard, Louisiana, and later organized and commanded Base Hospital No. 35 of the A.E.F. From 1922 until 1926 General Lull was Director of the Department of Preventive Medicine at the Army Medical Center. In 1929 he was appointed Medical Adviser to the Governor General of the Philippine Islands, where he served for three years. He had charge of the Vital Records Division of The Surgeon General's office from 1932 to 1936.

The following four years he was Director of the Department of Sanitation at the Medical Field Service School, Carlisle Barracks, Pennsylvania. In 1940 he returned to The Surgeon General's Office as Chief of Personnel Service until May 31, 1943, when he was appointed Deputy Surgeon General. Born in Pennsylvania, March 10, 1887, General Lull received his M.D. degree from Jefferson Medical College in 1909, a Certificate of Public Health from Harvard Technology School of Public Health in 1921, and his degree of Doctor of Public Health from the University of Pennsylvania in 1922.

MAJOR GWYNN NEW DIRECTOR OF RECONDITIONING CONSULTANTS DIVISION

Major Henry B. Gwynn, formerly Deputy Director of the Reconditioning Consultants Division, Office of The Surgeon General, was appointed Director of that division, December 1, succeeding Colonel Augustus Thorndike, who is returning to civilian practice of orthopedic surgery in Boston.

A member of the Army Medical Corps since 1942, Major Gwynn served as Medical Consultant in the Southwest Pacific for two years before his assignment to the Office of The Surgeon General.

In civilian life Major Gwynn practiced internal medicine and was Associate Professor of Clinical Medicine at Georgetown University School of Medicine. He has served as Chairman of the Public Relations Committee of the District of Columbia Medical Society and organized the Diagnostic Clinic at the Washington Medical Center.

NAVAL MEDICAL OFFICERS PRESENTED WELLCOME AWARD

For the sixth consecutive year, Naval personnel were presented the Wellcome Award at ceremonies, December 11, at the National Naval Medical Center, Bethesda, Md.

Joint recipients of the award, which was established by the late Sir Henry Wellcome, were Captain Joseph S. Barr, M.C., U. S. N. R., Newton Center, Mass.; Captain R. H. Draeger, M.C., U. S. N., San Francisco, Calif., and Commander W. Warren Sager, M.C., U. S. N. R., Washington, D.C.

Their scientific paper, "Solid Blast Personnel Injury," was selected by the Association of Military Surgeons as the best submitted in the annual competition.

The presentation of the honorarium and scroll accompanying the award was made by Captain Robert E. Duncan, M. C., U. S. N., Medical Officer in Command at Bethesda. A gold medal also normally goes to the winner but the medal has not been cast since the beginning of the war, the die having been destroyed in the London blitz.

Captain Barr is in charge of the orthopedic service at Bethesda and Captain Draeger is executive officer of the Naval Medical Research Institute. Commander Sager, now on terminal leave, formerly was attached to the surgical staff at Bethesda. During the war he served as Chief Surgeon of the U.S.S. Sanctuary, a hospital ship. He is Associate Clinical Professor of Surgery at George Washington University School of Medicine.

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LETTERS FROM MEMBERS IN THE SERVICES

From Major Irvin Hantman, 382nd Station Hospital, c/o Postmaster, San Francisco, Calif.:

Dear Ted: Your very welcome news letter of October 8 has finally caught up with me, and it was a pleasure to read it. I read with great concern in your previous letter that you were undecided whether or not to discontinue these letters, now that the shooting was over. I can assure you that I am happy you decided to keep them up, as the war is far from over for us who are 10,000 miles from home.

Your interesting little anecdotes always delight me, and I feel that you are conversing with me personally. These little touches from home are more than welcome.

My outfit spent about 4 months in Okinawa, long enough to fight two typhoons, the latter of which was quite a breeze. I was on duty at that time taking care of the women and children evacuees from Jap prison camps, and we had a campful of Aleutian women and children including a baby of 21 days. The wind and rain blew down about 20 of 24 buildings in our area. Quite some fun to watch floors, and sections of buildings and at times entire buildings, floating gracefully through the air. Our Aleutians, about 70 nurses and 50 enlisted men, found shelter in a Red Cross doughnut factory, which remained intact, except for sections of the roof, through which water streamed every two feet. But the doughnuts and coffee, both heavily diluted with rain water, helped the situation.

Incidently when I got to Okinawa after a 34-day sea jaunt, I found a very sweet letter from the War Department telling me I had been a Major for over a month. This made the situation a lot pleasanter.

But Okinawa was just a camping place for our outfit which is a 500-bed Station Hospital. We were scheduled to go further north, and on November 2, we came to Fusan (or Pusan), Korea, the southernmost city on Korea. It has a beautiful harbor and as we approached in an LST the city looked very attractive, surrounded on three sides by gently rolling hills, the sides of which were characteristically terraced in typical oriental style. The city of Fusan is pure paradox, with modern looking stone and cement buildings—tile seen in profusion, street cars, 1928–1932 vintage autos, some run by carbide and by charcoal burners, contrasted with multitudes of people living under primitive conditions. Women with babies on their backs, carrying them as papooses, and with tremendous loads balanced gracefully on the tops of their heads remind you of some of our girls trying to gain physical poise and gracefulness by walking with books balanced on their noggins. The odors are indescribable, being a combination of fresh fish, rotting fish, human excreta (which is quite often—and very guilelessly—publicly deposited) and the food odors of numberless small eating places. Quite amazingly, the city has a profusion of clock and watch repair shops, barber shops (although no one seems ever to need a shave or a haircut), and small sidewalk shoe repair shops.

The city at present is jammed with Japs from all over Korea being evacuated to Japan, and incoming Koreans brought back from Japan. One side of the street has long lines of Japs with their household goods, and children, everybody carrying something, going out, and on the other side of the street the Koreans going in the opposite direction. Incidently, we call these natives "gooks" and were quite chagrined to find out that the Korean name for Americans is "Mee gooks." I could ramble on and on trying to describe this indescribable place, and if I had your gift of reporting, I would do so, but I'd never get finished at my speed.

I'm keeping quite busy here, as I'm probably the only E.N.T. man in Southern Korea—but I, like the other soldiers, am dreaming only of when I can get home. I ought to be eligible in February or even before—after three and a half years of service, unless the Army finds a new excuse for keeping us.

Meanwhile, a very happy Christmas and New Year. Regards to all you see.

From Commander Robert M. Bolton, U. S. Naval Hospital, Oakland, Calif.:

Dear Ted: Let me again tell you how much I appreciate your letter and the copies of *Medical Annals*. I am back at U. S. Naval Hospital, Oakland, Cal., as a patient . . . I hope I can get back to Washington before too much longer.

You may have heard that I was made Captain as of Nov. 10 but cannot accept it as long as I am on the sick list. I was highly gratified to get it in spite of the fact that I have been either on the sick list or on limited duty since August of last year.

From Commander Perry W. Gard, U.S.S. Corregidor, c/o Fleet Post Office, San Francisco, Calif.:

Dear Ted: . . . I am getting close to the gun! In fact, I should be ready to call it a day on the first of the year. That momentous event is however hinged on action in Washington aimed at securing me a relief since the Captain will not detach me until I am replaced. Isn't it tough to be a "key man"! However, that is the way it stands just now. And how I am praying that this bloke will put in an appearance before the Mighty C has to go west again. Usually the air personnel are sent to San Diego so I presume I shall start the trek eastward from that port and in any case be separated in D. C., then I plan on joining Mrs. Gard and the children in Florida, where they have been since I went to sea, for a period of renewing acquaintances and then return to D. C. sometime about the first of February. So you can well imagine my feverish interest in the calendar. Had a rather interesting experience the other night—went over to our escorting destroyer in our whaleboat in the pitch black to handle an emergency which they couldn't cope with. I will tell you about it sometime. And do remind me to show you my action pictures on a carrier. I rather think you would enjoy them. Just think how bored you will be when we all get back!

One thing more. I do want to enter a polite bitch about your failure to take note of my selection for Commander last summer. I will have you know that was one of them done the hard way before the Navy began to promote everybody and his brother this fall!

Again, Ted, I do want to take this opportunity to thank you for a splendid job you have done in the Society. The receipt of your letters and the *Annals* has always been a very welcome experience and one much appreciated.

News and Personals

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Attending the meetings of the **House of Delegates of the American Medical Association** in Chicago, December 3-6, were Dr. Coursen B. Conklin, the Medical Society's Delegate, Dr. William Earl Clark and Theodore Wiprud, President and Secretary of the Society, respectively, and Dr. Herbert P. Ramsey.

Dr. Roger I. Lee of Boston was installed as President of the A. M. A., while Dr. Harrison H. Shoulders of Nashville, Tenn., was chosen President-elect. Dr. Shoulders is Assistant Professor of Clinical Surgery of Vanderbilt University and for many years has been Speaker of the House of Delegates.

San Francisco was selected as the site of the 1946 General Convention to be held during the month of July.

At the **Tenth National Assembly of the United States Chapter of the International College of Surgeons,** which was held at the Mayflower Hotel, December 6–8, Dr. Herbert Acuff, of Knoxville, Tenn., was reëlected President, and Dr. Custis Lee Hall, of Washington, was chosen President-elect. Among the Vice Presidents who were reëlected to serve was Dr. Charles Stanley White.

Honorary Fellowship in the College was conferred upon Dr. W. W. Babcock of Temple University; Brigadier General George R. Callender, M.C., U. S. A.; Major General Paul R. Hawley, Acting Surgeon General of Veterans Administration; and Rear Admiral Winchell M. Craig, M.C., U. S. N. R. Dr. Arthur C. Christie was made an Associate Fellow in Roentgenology and Dr. Oscar B. Hunter, an Associate Fellow in Pathology. Dr. Max Thorek of Chicago, Secretary of the College, was decorated with the Peruvian Order of the Sun by Dr. Umberto Fernandez Davilla, Minister Counselor of the Order of the Sun.

Announcement was made that the next biennial meeting of the College would be held in Lima, Peru, March 25–27, 1946.

CALENDAR OF MEETINGS

December 10	Committee on Postgraduate Education
December 12	Scientific Meeting of Society
December 17	Program Committee
December 21	Committee on Cancer Control
December 28	Grievance Committee

The American College of Physicians will resume its annual meetings in 1946, having chosen Philadelphia as the next place of meeting, with the date scheduled as May 13–17. Headquarters will be at the Philadelphia Municipal Auditorium, 34th Street below Spruce.

The 42nd Annual Congress on Medical Education and Licensure will convene in the Palmer House, Chicago, February 11 and 12, 1946.

The American Board of Ophthalmology announces that the 1946 examinations will be given in the following cities at the dates specified:

Chicago: January 18–22 and October 9–12
New York: April 10–13 (approximately)
San Francisco: June 22–25

A new ruling requires that previously accepted candidates mail their lists of surgery to the Board office at least 60 days prior to their examination. All new applicants are now required to send their lists with applications.

The National Research Council, acting as agent for various national societies, is offering additional fellowships which are available to newly separated Medical Department officers holding M.D. or Ph.D. degrees. These fellowships are in the fields of cancer research and anesthesiology.

The Council's newly appointed Committee on Growth will administer funds provided by the

American Cancer Society. Fellowship stipends vary from $2,000 to $3,000 per year, and are intended, as a rule, for those under 34 years of age. A limited number of senior fellowships for older, particularly qualified individuals planning to specialize in cancer research are available for three-year periods with stipends of $3,000 to $6,000 per annum. Applications should be filed before February 1, 1946.

For fellowships in anesthesiology, supported by the American Society of Anesthesiologists, applications should be filed before July 1, 1946.

For further information and application forms, write to The Chairman, Division of Medical Sciences, National Research Council, 2101 Constitution Avenue, Washington 25, D. C.

The faculty of **Georgetown University School of Medicine,** assisted by invited guest clinicians and lecturers, will offer a Refresher Course to returning medical officers of the armed forces. The course will continue for 12 weeks, beginning February 4 and closing, April 27. A faculty committee under the chairmanship of Dr. Fred R. Sanderson, Professor of Surgery, has arranged an interesting program which comprises an intensive, yet comprehensive review of the noteworthy advances recently made in the various fields of medical practice.

A descriptive folder of the course was received just as the ANNALS was going to press. A copy can be obtained by communicating with the School.

The Section on Neurology and Psychiatry met in the Society's library, January 10. The following program was presented: "A Case of Herpes Zoster Following Excessive Sodium Chloride Ingestion," Dr. Michael M. Miller; "Prefrontal Lobotomy—Factors Influencing the Prognosis," Drs. James W. Watts and Walter Freeman.

The Section on Gastroenterology held a dinner meeting, December 10, in the Pan American Room of the Mayflower Hotel, with Dr. William T. Gill as host. Dr. Arthur C. Christie addressed the Section on "Fifty Years of Radiology," emphasizing the clinical aspects of X-ray in the practice of medicine.

At the meeting of the **Executive Board,** November 26, a new committee was created to be known as the **Civilian Rehabilitation Committee.**

Approval was given to the appointment of **Dr. George V. Simpson** as a member of the Classification Committee. Also confirmed was the appointment of **Dr. Karl C. Corley** as a member of the Committee on Industrial Medicine to succeed **Dr. Frederick C. Schreiber,** who was unable to serve.

Dr. Frederick O. Coe was nominated to succeed himself as Vice President of the Washington Academy of Sciences representing the Medical Society.

The Washington, D. C. Ophthalmological Society held its regular meeting, January 7, in the Medical Society's auditorium. The guest speaker, Captain Clifford A. Swanson, M.C., U. S. N., addressed members on the subject, "Causes of Uniocular and Binocular Blindness in the Navy and Marine Corps in World War II." He also made some remarks about the Second Pan-American Ophthalmological Conference. A motion picture, "Manufacture of Acrylic Eye," was presented through the courtesy of the Medical Corps of the U. S. Navy.

Case presentations were made by Drs. J. A. Sansoucy, Samuel H. Skloff and Jules B. Chapman.

The Clinico-Pathological Society met January 8 at the home of Dr. William P. Herbst. Colonel Charles R. Rein, M.C., U. S. A., spoke on "Recent Advances in the Serodiagnosis of Syphilis." Discussion of the paper was led by Dr. Oscar B. Hunter.

At the meeting of the **District of Columbia Dental Society,** January 8, Dr. E. Clarence Rice appeared on the program. He discussed "Dental Problems of the Diabetic Patient." Dr. Sterling V. Mead spoke on "Socialization of the Professions and How It Will Affect Every Dentist."

Dr. Hugh S. Cumming, Director of the Pan American Sanitary Bureau and former Surgeon General of the United States Public Health Service, was honored at a testimonial banquet, December 20, for his 25 years of service. The banquet was held at the Mayflower Hotel under the auspices of the International Medical Club. Dr. Walter A. Bloedorn, President of the Club, presented Dr. Cumming to the assembled guests, who included physicians and representatives of 18 Latin-American countries.

The Grand Cross of the Order of Finlay was presented to Dr. Cumming by Dr. Alfred Saavedra for the Cuban government. He also received a congratulatory letter from former Secretary of State Hull which stated that his work "has become historic and outstanding even beyond the confines of this hemisphere."

Among others who spoke in praise of Dr. Cumming's accomplishments were Dr. Leo Rowe, Director General of the Pan American Union; Dr. Paula Souza, representing the Brazilian Ambassador; Dr. Hector Castro, Ambassador of El Salvador; and Dr. A. A. Moll, Secretary of the Pan American Sanitary Bureau.

Dr. Cumming was appointed Surgeon General of the United States Public Health Service by President Wilson in 1920, and retired from this office in 1936. Since then he has served as Director of the Pan American Sanitary Bureau, which was created by treaty in 1902 as the first international health organization in history. Recognition has come to him in many ways for his outstanding contribution in the field of national and international health and sanitation.

Dr. Frank D. Costenbader represented the Medical Society in Chicago, November 30 and December 1, at a Conference on Voluntary Prepayment Medical Care Plans sponsored by the Council on Medical Service and Public Relations of the American Medical Association.

Dr. William P. Herbst was elected President of the District Social Hygiene Society, December 13, succeeding **Dr. Henry H. Hazen** in office. Dr. Herbst is Professor of Clinical Urology at Georgetown University School of Medicine and President-elect of the Medical Society.

In a statement issued by **Vice Admiral Ross T. McIntire, Chief of the Bureau of Medicine and Surgery,** on December 6, he described a long-term program for training specialists which has been inaugurated by his Department. According to Admiral McIntire, the program "intended to fulfill more adequately the medical and surgical needs of an expanded peacetime Navy . . . will make available to medical officers a complete term of specialization training comparable to the best obtainable in civil life."

Dr. Wm. Calhoun Stirling, Consultant in Urology to the Bureau, is listed as one of those who has assisted in the development of this program.

Dr. Wallace M. Yater has been appointed Associate Editor of the *American Heart Journal.*

A new periodical, *Occupational Medicine,* to be published monthly by the American Medical Association, makes its appearance this month. It is intended that the scope of the new publication will not be that of a specialty journal but will encompass the interests of all practitioners and of many specialties. **Dr. Winfred Overholser** has been appointed a member of the Editorial Board.

MEETINGS

Wednesday, February 13

The D. C. Pharmaceutical Association will sponsor the following program:

1. "Presentation of the Action of Anti-infective Drugs," JOHN C. KRANTZ, PH.D., SC.D., Professor of Pharmacology, University of Maryland School of Medicine.
2. "Current Information on New Drugs including Benadryl, Streptomycin, Folic Acid, Amino Acids, Gelatin Suspension and Others," ROBERT P. HERWICK, M.D., PH.D., Medical Director, United States Food and Drug Administration.

Wednesday, February 20

Speakers and subjects to be announced.

Wednesday, February 27

The program will be presented by the *Section on Gastroenterology.* Speakers and subjects will be announced.

GEORGE REUBEN SORRELL, M.D.

(1876–1945)

Dr. George R. Sorrell, a Life Member of the Medical Society of the District of Columbia, died December 10, 1945, at Sibley Hospital after a brief illness. He had practiced in the District of Columbia for 45 years, maintaining his office at his residence, 616 F Street, S.W.

Although he was born in Comorn, Virginia, April

12, 1876, Dr. Sorrell had lived in the District of Columbia since 1888 and attended the public schools here. He graduated in medicine from Columbian University (now George Washington University) in 1898 and was licensed to practice in the District in 1900.

He became a member of the Medical Association of the District of Columbia, which amalgamated with the District Medical Society, in 1902. He was a Fellow of the American Medical Association, and held membership in the George Washington University Medical Society and Lafayette Lodge No. 19, F.A.A.M.

His wife, Mrs. Mary Sheehan Sorrell, preceded him in death four years ago. A son, Major William G. Sorrell, M.C., A.U.S., stationed in the Canal Zone, survives him together with four sisters, Miss Alice B. Sorrell, Mrs. Agnes D. Montgomery, Mrs. Kate S. Outwater, and Mrs. Lola Purks, all of Washington, and a brother, Joseph E. Sorrell, of Fredericksburg, Va.

RICHARD FRANCIS TOBIN, M.D.

(1872–1945)

Dr. Richard F. Tobin, an Active Member of the Medical Society of the District of Columbia, died December 21 after an illness extending over a period of two years. He resided at 122 11th Street, S.E.

Dr. Tobin was a native Washingtonian, born November 13, 1872. After graduating from Georgetown University School of Medicine in 1905, he served as an intern and resident physician at Washington Asylum Hospital. He began active practice in the District of Columbia in 1907.

In 1908 he became a member of the Medical Association of the District of Columbia, which later amalgamated with the Medical Society of the District of Columbia. He was a Fellow of the American Medical Association and was affiliated with the Knights of Columbus.

Surviving are his wife, Mrs. Mary E. Tobin, and two brothers, Charles Tobin of Suitland, Md., and William P. Tobin of Manassas, Va.

Oral Penicillin—Burke et al

(*Continued from page 26*)

4. Dawson, H., and Hunter, T. H.: Treatment of subacute bacterial endocarditis with penicillin. J. A. M. A., 1945, **127**, 129.
5. Meads, M., Harris, H. W., Finland, M.: Treatment of bacterial endocarditis with penicillin. New England J. Med., 1945, **232**, 463.
6. Paullin, J. E., and McLoughlen, C. J.: Treatment of subacute bacterial endocarditis with penicillin. Ann. Int. Med., 1945, **22**, 475.
7. Spink, W. W., and Hall, W. H.: Penicillin therapy at University of Minnesota hospitals, 1942–1944. Ibid., 1945, **22**, 510.
8. Burke, F. G., Ross, S., and Strauss, C. S.: Oral administration of penicillin; preliminary report. J. A. M. A., 1945, **128**, 83.
9. Ross, S., Burke, F. G., and McLendon, P. A. Penicillin by mouth: a clinical trial. J. A. M. A., 1945, **129**, 327.
10. Rammelkamp, C. H.: Method of determining the concentration of penicillin in body fluids and exudates. Proc. Soc. Exper. Biol. & Med., 1942, **51**, 95.

Health Program—Henry

(*Continued from page 46*)

the American people under the present system—as revealed by the numbers rejected by the draft for physical and mental defects. This is all bunk, say the doctors. The American people are the healthiest in the world. No sort of medical service ever could have remedied a good many of the defects for which men were rejected by the Army. Doctors cannot repair constitutional weaknesses. They cannot raise subnormal intelligence. A good many of those rejected by the draft boards would have had the same defects if physicians had danced attendance on them every instant since they were born. They could thank medical men, as it was, for the fact that they were alive—instead of having perished as subnormal babies.

Furthermore, Army standards were very strict. The British Army—and also the German Army—was filled with men who never could have gotten through the gate of an American military post and many of them made very good soldiers.

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PRESENT STATUS OF RESEARCH ON THE RH FACTOR*

ANNE D. McLAUGHLIN, Ph.D.
Washington

Blood is divided into two elements, erythrocytes which carry factors behaving as antigens, and plasma which carries factors behaving as antibodies. The factors carried by the erythrocytes are called agglutinogens; those carried by the plasma, agglutinins. When the blood of two individuals is mixed and an agglutinogen meets its specific agglutinin, a reaction takes place resulting in an agglutination of red blood cells, and sometimes hemolysis. Erythrocytes may carry the following sets of agglutinogens:

1. The major blood groups A, B, AB, O. Their identification is the basis of blood typing and matching.
2. Minor blood groups A_1, A_2, A_3, A_1B, A_2B, A_3B, which are weak antigens, and assume importance only after repeated transfusions. Normal plasma has no agglutinins for these.
3. Subgroups M, N, and MN. These are poor antigens, seem to be incapable of producing corresponding antibodies, and play no part in transfusion reactions, but are important in determining paternity.
4. Subgroups X, P, H, and E, as yet only of experimental interest and academic research.

Such was the status of known blood factors until 1937 when Landsteiner and Wiener observed that some rabbit immune sera produced from the blood of rhesus monkeys reacted with human bloods containing the agglutinogen M. In 1939 Levine and Stetson[1] described a new agglutinable blood factor independent of A, B, AB, M, N, or P. This factor was found in the blood of a mother who had produced a macerated fetus. It was also found in about 80 per cent of all bloods. However, it was not until 1940 that Landsteiner and Wiener,[2] in a one-page article, finally named this new factor. They immunized rabbits with red blood cells of a rhesus monkey and obtained an immune serum which contained agglutinins specific for a human agglutinogen, different from A, B, M, N, and P. Because rhesus blood was used in its production, the factor was given the name Rh.

It has been found by 4 investigators, Landsteiner and Wiener[3] and Fisk and Foord,[4] that approximately 85 per cent of the white people studied were Rh positive. In England, Boorman, Dodd and Mollison[5] found that 85.15 per cent of 1,610 people studied were Rh positive. Investigations by Levine[6] on the distribution of the Rh factor among Negroes in New York City revealed a higher incidence of the positive type, 93.7 per cent; among the American Indians, 92.3 per cent; and among the Chinese, 99.3 per cent. Extension of these studies to other races should yield results of significance from the standpoint of racial origins.

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*From the Chemo-Medical Research Institute, Georgetown University.

There is no very definite information relative to the physical properties of this Rh substance. It is presumed to be a carbohydrate fixed to the proteins of the red blood cells. It is not found in commercial plasma or serum. It is found in the red cells only, and not in the fixed tissue cells and saliva as are the factors A and B. M and N likewise occur in red blood cells only and have no normal agglutinins against them. Moreover, no anti-M or N agglutinins ever develop if blood containing the M or N factors is injected into persons without these. The antibodies which are formed against this particular Rh factor are present in the serum or plasma of the blood. Antibodies are very likely protein in nature and are contained in the globulin fraction of the blood.

Landsteiner and Wiener[3] have shown that the Rh factor in the blood cells is transmitted in the human offspring as a Mendelian dominant. Wiener, Sonn and Belkin[7] in 1944 proposed the theory of 6 allelic genes or multiple alleles to account for the existence of variants of the Rh agglutinogen. The dispersion of the Rh factor does not vary significantly among any of the 4 blood groups; also it is evenly divided between the sexes. The Rh factor when positive can be shown to be present in the fetal blood circulation, and, once established, the Rh factor remains constant.

All Rh negative individuals do not normally have anti-Rh agglutinins in their plasma, while in contrast, all individuals among the ABO groups whose red cells lack A or B agglutinogens do have the corresponding anti-A or anti-B agglutinins in their plasma. However, Rh negative individuals normally without anti-Rh agglutinins in their plasma are liable to form them if Rh agglutinogen is introduced into their circulation. These anti-Rh agglutinins are called immune bodies or preferably isoimmune bodies, since they are found in the same species. Anti-Rh agglutinins may be formed in 2 ways: (1) They may be introduced in persons of both sexes when Rh positive blood, whose red cells contain the Rh agglutinogen, is transfused into Rh negative individuals; and (2) in Rh negative women, after becoming pregnant with an Rh positive fetus, the fetus having inherited the Rh agglutinogen from the father. Consequently, from the transfusion standpoint, the importance of the presence of anti-Rh agglutinins, developed as a result of transfusion or of pregnancy, is that a subsequent transfusion of Rh positive blood will produce a serious reaction. Therefore, since it has been shown that at least 85 per cent of bloods are Rh positive, the chances of incompatible blood being given when transfusion is required are great, unless Rh negative blood of the appropriate ABO group is selected.

Once a person with Rh negative blood is immunized either by Rh positive fetal blood or by repeated transfusions, that person remains immunized for many years, if not permanently. Levine[8] reports a case in which a transfusion of Rh positive blood carried out 11 years after the last antigenic stimulus was tolerated, but the following transfusion of blood from the same donor resulted in severe shock and considerable damage to the kidneys. This is a typical example of the phenomenon known as the "anamnestic reaction," which may be defined as "the production in response to an antigenic stimulus of an antibody that has been produced in the tissues on some previous occasion."

The development of anti-Rh agglutinins by Rh negative persons may not occur after the first or second transfusion of Rh positive blood and in several cases has been known to occur only after repeated transfusions of Rh positive blood. As a rule, it can be suspected then from the poor response to the transfusion. This is characterized by the failure of the hemoglobin to rise, the development of hemolytic jaundice, or the more serious signs of hemolysis, such as hemoglobinuria.

The Rh factor in human blood has received greatest attention in relation to erythroblastosis foetalis. Levine and Katzin[9] quickly recognized the importance of this blood factor and applied the discovery to an understanding of the cause of intragroup transfusion reactions during pregnancy, of the pathogenesis of repeated miscarriages and deaths of the newborn, and of the hemolytic anemias of the newborn.

Levine[8] showed that a father who possesses the Rh antigen in his red cells may transmit this dominant Mendelian character to his offspring, who in turn may immunize the mother, if she is lacking in this agglutinogen. If the mother is Rh negative and the fetus Rh positive, agglutinogens in the red cells of the fetus may pass through a break in the villi of the placenta and immunize the mother. The mother will then develop anti-Rh agglutinins in her plasma which again are capable of passing through the placenta and destroying the baby's red blood cells, with the production of jaundice, anemia or erythroblastosis. The latter name has been given to a group of fatal maladies encountered in newborn infants. The classical forms of this group have been frequently described. The infant may be born dead or moribund and be edematous from head to feet. This is referred to as congenital hydrops foetalis. It may be jaundiced over the entire body, or it may become jaundiced within 24 hours. This is referred to as icterus gravis neonatorum. Or it may be normal at birth but develop severe anemia within a few days, a condition called congenital anemia of the newborn. Kariher and Spindler[10] and others suggest the term hemolytic anemia of the newborn, since hemolytic anemia is the most important feature of these disorders.

The term erythroblastosis has been used because of the continued presence of nucleated red blood cells even younger than normoblasts in the circulation. This is compensatory to overcome the excessive destruction of red cells of the infant and is therefore only coincidental. This hemolytic destruction of the erythrocytes in the newborn should not be confused with physiologic icterus neonatorum or the physiologic anemia which occurs as a result of normal physiologic hemolysis necessary to destroy the excess of erythrocytes carried over from fetal life, during which time they were needed to maintain fetal tissue respiration under conditions of low oxygen. It is in no way related to the hemorrhagic disease of the newborn, a condition attributable to a deficiency of prothrombin, and which is improved, if not cured, by injection of whole blood and vitamin K.

Anti-Rh agglutinins, unlike the ordinary anti-A and anti-B agglutinins, are "immune" bodies, and therefore at first increase in strength, then decrease, and finally disappear. They may persist, however, for several years, and, even after all evidence of agglutinins has disappeared, sensitivity to the Rh agglutinogen may still persist.

In the light of present evidence, if hemolytic disease occurs in the infants, past or present, of a mother, it may be regarded as a possibility that anti-Rh agglutinins are present in her blood and that transfusion will be extremely dangerous for her unless the blood comes from an Rh negative donor of suitable group. This should be a useful safeguard, but as long as the infant remains in the uterus there is no way of knowing that it has hemolytic disease. Again, if an Rh negative woman receives repeated transfusions of Rh positive blood, she may form anti-Rh agglutinins and in her next pregnancy her infant develop hemolytic disease.

Adequate evidence exists to indicate that all cases of hemolytic disease of the fetus are not caused by the Rh factor, because it has been shown to be related etiologically only in about 90 per cent of the cases. The opinion that other known and unknown factors related to isoimmunization may be involved in those cases which do not meet the requirements of the Rh theory, seems justified. For example, when the fetal red blood cells contain A or B agglutinogen and the mother's red blood cells lack them, the fetal cells may be destroyed by anti-A or anti-B agglutinins. If the fetus is AB, the mother's serum is certain to contain an iso-agglutinin for A or B or both except in 1 case in 6, in which the mother will also be group AB.

When the mother is Rh positive, it seems certain, if iso-immunization is responsible, that another antigen must be involved. Race, Taylor, Cappell and McFarlane[11] report 6 cases of erythroblastosis in all of which the mothers were Rh positive. Three of the fathers were Rh negative, 1 Rh positive, and the other 2 could not be examined. In the case of the Rh positive mother and father, the mother's serum (Group O, Rh positive) contained a very powerful antibody. This serum gave clear-cut positive reactions with the red blood cells of 80 per cent of a large numper of unselected Group O persons, including her erythroblastic child (Group O, Rh positive). When tested against Rh negative bloods, it was found to agglutinate strongly a series of 50 consecutive samples. After removal of the anti-A and anti-B iso-antibodies, the serum still agglutinated the father's cells (Group A, Rh positive). This antibody is not specific for any of the blood cell antigens, A, B, O, M, N, P, Rh, but it is suspected that it is similar to the irregular agglutinin found by Levine, Burnham and Katzin[12] in 1941 in the blood of an Rh positive mother with an Rh negative husband and an erythroblastic child and named by them anti-Hr (i.e., Rh in reverse). According to Wiener[13] this irregular agglutinin acts on Rh negative cells and certain Rh positive cells which he designates Rh_2 on the analogy of the subdivisions of the A group. The work of Davidsohn and Toharsky indicated that the subdivision of the Rh was much more complex than this, and the work of Wiener and his associates[7] bears this out.

According to the nomenclature proposed by Wiener[7] the 3 varieties of Rh agglutinins are designated as anti-Rh, anti-Rh_1, and anti-Rh_2 respectively. The anti-Rh or standard Rh agglutinin corresponds in specificity with the original anti-Rh sera obtained by Landsteiner and Wiener[3,14] by immunizing guinea pigs and rabbits with the blood of rhesus monkeys. Such sera agglutinate the sera of 85 per cent of white individuals. Human sera giving parallel reactions with the animal immune anti-rhesus sera have been obtained from patients who have had hemolytic reactions to blood transfusions and mothers of erythroblastic babies.

Human sera corresponding to the so-called anti-Rh_1 agglutinin were first described by Wiener,[15] and similar sera were subsequently obtained by Levine, Burnham, Katzin, and Vogel,[12] by Davidsohn and Toharsky[16] and others. Anti-sera agglutinate the bloods of approximately 70 per cent of white individuals of New York City. However, there is a small percentage of bloods, negative with the standard anti-Rh sera, which are clumped by Rh_1 antisera, and these are now designated as Rh′. The most common human anti-Rh sera actually give 87 per cent positive reactions, and Levine has shown that such sera, now designated Rh′, contain the agglutinins anti-Rh and anti-Rh_1.

The third variety of anti-Rh agglutinin, anti-Rh_2, reacts with the bloods of approximately 35 per cent of white individuals in New York City. There is a very small percentage of bloods called Rh″ which are negative with the standard anti-Rh sera and yet clump the anti-Rh_2 sera. To date all human anti-sera found containing the anti-Rh_2 agglutinin also contain the standard anti-Rh agglutinin, and to indicate this, the sera are termed anti-Rh″.

Wiener and his co-workers[7] assume the existence of a series of allelic genes, Rh_1, Rh_2, Rh′ and Rh″, Rh and rh named after the serologic characteristics which they exhibit. The gene Rh is dominant and the gene rh recessive to the others. In a homozygous individual, it gives rise to the negative type (rhrh). The gene Rh′ determines an agglutinogen or antigen Rh′ which reacts with anti-Rh_1 but not anti-Rh_2 or anti-Rh agglutinins. Likewise the gene Rh″ determines an agglutinogen or antigen Rh$''$ which reacts with anti–Rh$_2$ but not with anti-Rh$_1$ or anti-Rh agglutinins. The gene Rh determines an agglutinogen Rh which reacts with the standard anti-Rh agglutinin but not with anti-Rh$_1$ or anti-Rh$_2$.

On the other hand, the genes Rh$_1$ and Rh$_2$, which determine the agglutinogens Rh$_1$ and Rh$_2$, each have the ability to react with 2 of the 3 primary Rh agglutinins. Rh$_1$ reacts with anti-Rh$_1$ sera and anti-Rh, but not anti-Rh$_2$; Rh$_2$ reacts with anti-Rh$_2$ and anti-Rh, but not anti-Rh$_1$. However, because the bloods of types Rh$_1$ and Rh$_2$ react with 2 distinct agglutinins, this does not mean that they contain 2 genetically separate corresponding properties. These agglutinogens, according to Wiener, are assumed to be due to the action of single genes and are, therefore, inherited as a unit, their serologic properties being ascribed to the presence of 2 or more "partial antigens" within the molecule. Their behavior is comparable to the reactions of subgroup A with sera anti-A and anti-A$_1$.

Since every individual has 2 genes of every allelic series, 1 derived from each parent, each must have a pair of Rh genes. In this particular case, we assume the set of alleles contains not 2 members but 6, only 2 of which occur in a somatic cell at a time and only 1 in a gamete.

As Wiener shows, 21 genotypes are theoretically possible under the 6-gene theory, and if the phenotype is assumed to represent the combined effect of 2 genes, the 21 genotypes give rise to 8 phenotypes.

Ninety-seven families were studied. The bloods of parents and children were tested for the major antigens A, B, AB, O; the minor antigens A$_1$, A$_2$, A$_3$, A$_1$B, A$_2$B, A$_3$B; the subgroups M, N, and MN, and the Rh, rh, Rh$_1$, Rh$_2$, Rh$'$, Rh$_1$Rh$_2$.

The validity of the 6-gene theory seems well established by this study.

Apart from the theoretical significance of the existence of many Rh blood types, the study is important for several reasons. First, it explains the puzzling differences in the human Rh antisera. Second, it justifies the use of Rh tests in cases of disputed paternity. Lastly, to the geneticist, it furnishes another striking example of inheritance in man on the basis of multiple alleles.

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VIBRATORY FREMITUS; THE USE OF THE TUNING FORK IN AUSCULTATION AS A SIGN IN THE DETECTION OF CHEST DISEASES

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During the past few years the combined use of the tuning fork and stethoscope has been found to be a valuable adjunct in physical diagnosis, particularly of the chest. As far as can be learned, no previous report has been made of such a method, although it seems possible that some such reports may have been published previously by someone.

The technic is quite simple and easy. Usually information is obtained which is definitely confirmatory of that derived from other better known diagnostic methods. However, frequently indications of disease have been found in patients when other methods revealed no information at the time. In addition, this method can be used very often with satisfaction in examining patients who are speechless or unconscious or unable to coöperate with the examiner in the performance of other tests.

Method

Any ordinary tuning fork and stethoscope may be used. However, tuning fork no. 128C and the combination Bowles diaphragm stethoscope have been found to be most satisfactory. The patient may be placed in almost any position during this examination. I prefer that he be sitting upright, but valuable information can be obtained with him lying on his side or back. The tuning fork is set in vibration by striking it against the palm and then placing it at any point. I have obtained best results by placing it on the middle of the sternum when auscultating over the patient's back and on the thoracic spines when auscultating over the front of the chest (fig. 1). Best results were obtained by moving the stethoscope from a point on one side of the chest to a point at the same level on the opposite side and repeating this maneuver for different levels until the entire chest has been examined. Variations in the procedure include placing the tuning fork over any other point on the chest, over the larynx, or moving the stethoscope from the midline laterally on the same surface as the tuning fork. Usually satisfactory results are obtained with the patient holding his breath or breathing naturally during the examination. At other times, particularly in minimal consolidations, additional information may be obtained by having the patient breathe deeply in and out.

Results

On examination of the chest of normal individuals or those with no significant pulmonary pathology, vibrations caused by the tuning fork are heard very plainly on auscultation over the entire chest. To this phenomenon may be assigned the term "vibratory fremitus" for the sake of brevity. Actually, of course, the fremitus caused by the spoken voice is also vibratory or due to vibratory phenomena. However, for the purpose of distinguishing this procedure from the commonly employed method of auscultating or palpating vibrations caused by the spoken voice and referred to as "vocal or tactile fremitus," I believe the term "vibratory fremitus" will be useful. Vibratory fremitus is normally diminished over the heart and may be used with some success in outlining the borders of the heart. During deep inspiration the intensity of vibratory fremitus is increased and during expiration it again becomes decreased to the intensity found during quiet breathing or when the chest is at rest. A magnetic tuning fork would be preferable if available.

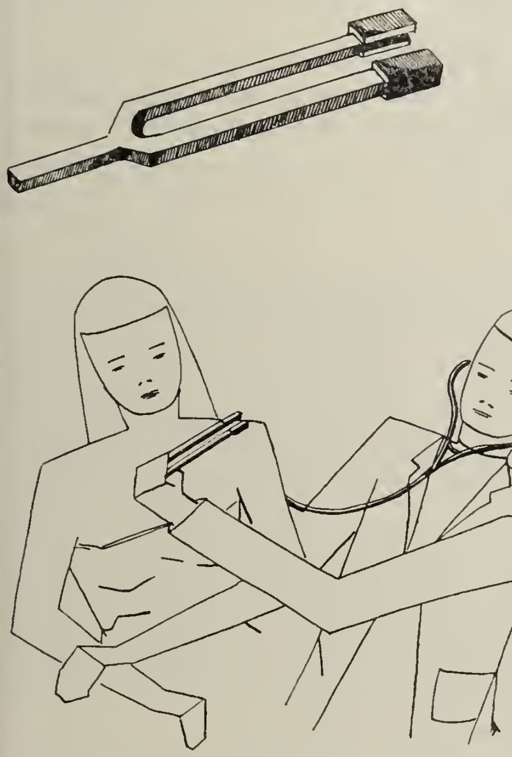

FIGURE 1

In the presence of pleural effusion, atelectasis, pulmonary infarction, or consolidation, variations in the intensity of the sound of the vibrating tuning fork are heard as compared with the uninvolved side. In all cases where there was pleural effusion or pleural thickening the sound of the vibrating tuning fork was diminished over the involved area as compared with other parts of the chest. In such cases the sound did not vary significantly during different phases of respiration.

In the presence of pulmonary consolidation due either to pneumonia, atelectasis, infarction, neoplastic infiltration, or surrounding cavitation and abscesses, vibratory fremitus was diminished over the involved areas. Occasionally I found this to be detected earlier than I could detect abnormal findings by other methods of physical examination. In occasional instances vibratory fremitus was increased over the involved area rather than diminished, and in such cases vocal fremitus and tactile fremitus were increased also.

In the presence of passive pulmonary congestion without pleural effusion or the other abnormalities listed above very little asymmetry in vibratory fremitus was detected. Likewise, in the presence of pneumothorax or cavitation without other significant pulmonary lesions, I found very little alteration in the results of this examination.

In some cases in which there was not a clear-cut difference between the intensity of vibratory fremitus over a normal area and over an area where pathology was suspected, additional information was obtained by auscultating over the suspected area until the sounds of the vibrating tuning fork disappeared; if the stethoscope was then moved to a normal area the sound of the tuning fork was heard again. In other words, the fading sounds of the weakening vibrations were transmitted less well through an abnormal area than through normal tissue.

I have found this method of examination to be useful for confirming the results of the ordinary methods of examination, in detecting sites of pulmonary disease earlier than could be found by common methods of physical examination and at times even before the appearance of distinctive roentgenologic changes. Still more important, however, from a practical standpoint was the common finding that by using this method of examination pulmonary disease could be detected in patients when other methods of examination were not possible or convenient at the time. This was particularly true in patients who

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THE TREATMENT OF GONORRHEA BY A SINGLE INJECTION OF A PENICILLIN-OIL-BEESWAX MIXTURE

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The rapid treatment of gonorrhea with penicillin in water solution has now become an established procedure. Many investigators, including Van Slyke and Steinberg[1] have reported successful results when regular penicillin has been administered intramuscularly at intervals of 2 or 3 hours for 4 to 8 injections. Cure rates have been reported by various investigators ranging from 86 to 98 per cent when 150,000 to 300,000 units have been used through a single course of treatment. A total of 200,000 units is generally considered adequate in the treatment of most cases of acute gonorrheal urethritis or cervicitis without complications. Chinn and Gillick[2] reported cure rates of 91.2 per cent in a series of 589 cases of gonorrhea. In this series a schedule was used consisting of 4 hourly injections of 50,000 units each.

Romansky and Rittman[3] have developed a penicillin peanut-oil-beeswax mixture, which, when injected intramuscularly, is slowly absorbed and the action of the penicillin prolonged. With a single injection of 300,000 units therapeutic blood levels are obtained through a 24-hour period. The use of this penicillin mixture in the treatment of gonorrhea has, in the hands of various investigators, produced excellent results. Romansky and Murphy[4] obtained 100 per cent cures using 150,000 units and 93 per cent cures when 100,000 units were used. Thomas has been reported to have obtained 98 per cent cures in 47 women using 150,000 units in a single injection. Van Slyke and Heller,[5] reporting on an extensive study by a large group of coöperating clinics and private physicians from all sections of the country, obtained cure rates of 91 to 92 per cent in 1,060 cases. A single injection of 200,000 units was used. Graham, Greenblatt and Cannefax,[6] using sodium penicillin in beeswax-oil, obtained 98.4 per cent cures with a single dose of 150,000 units.

The penicillin-oil-beeswax mixture consists of 4.8 per cent beeswax in peanut oil in which is suspended calcium penicillin. In this investigation a peanut-oil mixture was used containing 300,000 units of penicillin per cubic centimeter. The material is a solid at room temperature and must be well warmed and liquefied before use. Injections were made into the gluteal muscle with a 2½-inch needle, gauge 18 or 19. One cubic centimeter or a single dose of 300,000 units was administered.

The criteria for cure were similar to those used in our studies on water-soluble penicillin. Patients were examined and cultures taken 2 days and 7 to 10 days post-treatment. In almost all cases cultures were negative after the 2-day interval.

Two groups of patients were treated. One group of 75 patients was treated in the outpatient clinics of the Venereal Disease Bureau of the District of Columbia Health Department. A second group of 40 patients was hospitalized for 7 to 10 days at our Rapid Treatment Center. In the latter group the chances of reinfection were reduced to a minimum. In the first group the patients were told to abstain from alcoholic beverages and coitus during the observation period following treatment. However, in all cases of apparent failure of treatment careful histories as to exposure and contact information were obtained.

A total of 115 cases are herein considered in which our criteria of cure could be applied. The patients were men and women who presented themselves at the venereal disease clinics with clinical evidence of gonorrhea or were contacts to known cases of gonorrhea. The diagnosis in each case was confirmed bacteriologically by culture methods.

Among the 75 patients treated in the outpatient clinics 4 were considered failures. This is a cure rate of 94.7 per cent. Two patients failed to respond among the 40 hospitalized at the Rapid Treatment Center, a cure rate of 95 per cent. No opportunity was presented to re-treat the failures.

The clinical response in most of the cases was similar to that obtained in the treatment with penicillin in water. The response was very favorable in patients whose symptoms had been present for only a few days. In some the urine remained cloudy or shreds were present for as long as 7 to 10 days, but the smears and cultures were usually negative. In the clinical failures the symptoms generally persisted, and the discharge remained profuse. In women patients cultures were considered of the utmost importance, since absence of clinical findings is not a criterion of the absence of infection, and gonorrhea in the female is frequently in a quiescent state.

Only 2 patients showed reactions to the treatment. One developed a papular, itching rash within 24 hours after treatment which disappeared in several days. The second patient had a typical Herxheimer reaction and was later found to have syphilis.

It is important to consider the possibility of a concurrent syphilitic infection. Penicillin therapy may prolong the incubation period of syphilis if this infection is contracted at the same time as the gonorrhea. Serologic tests for syphilis should be made at the first visit and after 30, 60 and 90 days following the diagnosis of gonorrhea. Walker and Barton[7] advise that if there is evidence or suspicion of coexisting syphilis, penicillin therapy for gonorrhea should be withheld until a definite diagnosis of syphilis is established or eliminated.

In this series of patients penicillin blood levels were not determined. Kirby, Leifer et al[8] found that in 69 per cent of 54 cases levels were present for no longer than 12 hours and in 31 per cent for 16 to 28 hours. The shortest duration was 4 hours post-treatment. The excretion of penicillin in the urine rapidly declined after the first 12 hours, but small amounts could be detected for 72 hours or more. Romansky[9] has stated that blood concentrations of 0.19 to 0.25 unit maintained for at least 7 hours are considered sufficient for the cure of gonorrhea.

SUMMARY

A total of 115 cases of gonorrhea were treated with a single dose of a penicillin-beeswax mixture containing 300,000 units of penicillin. A cure rate of approximately 95 per cent was obtained. Cultures were made after 48 hours and 7 to 10 days following treatment.

This method of treatment appears to be a highly satisfactory procedure and suitable for both clinic and private practice. The possible

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RINGWORM OF THE SCALP*

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Prevalence

Ringworm of the scalp is not a new disease, but its widespread prevalence in areas of higher average levels of personal hygiene has been increasingly reported, especially in urban areas during the past several years. Sporadic cases frequently spreading to personal contacts have been observed in this city among persons in crowded areas for years. One outburst of approximately 30 cases occurred in a local orphan asylum about 15 years ago, and the Health Department was somewhat startled by the sudden appearance of 25 small boys suddenly appearing in the administrative office, all with bald patches about the size of a silver dollar on their heads. They came to appeal to the Health Officer for a treatment which would cure and stop the spread of the disease in the institution and permit them to resume their school attendance. X-ray therapy was suggested, and the flare-up was quickly eradicated.

Scalp ringworm is widely prevalent among children under 16 years old in Washington at this time. Since the opening of school this year, 793 cases have been seen at the Health Department and 225 cases at the Southwest Health Center. This constitutes only a small portion of the total cases among school children and their preschool and other children contacts in the home. Percentages of new cases discovered by filtered ultraviolet ray examination in schools where previous clinical cases had been reported have ranged from 5 to 10 per cent of the total enrollment of the individual school. In one school where no clinical cases were previously reported, no cases were discovered. Only 6 schools have been completely surveyed, but it is evident from present reports that the prevalence of scalp ringworm cases is widespread but not of equal distribution throughout the city.

Etiology

The species of ringworm fungi present in this epidemic, judging from clinical symptoms only, appear to be mainly the Microsporum audouini and Microsporum lanosum. It is possible that a few cases may be due to some of the rarer species, but in the great majority the clinical symptoms have been those usually presented by audouini infection. Very few cultural studies have been made, however.

Method of Spread

The infection first invades the stratum corneum of the skin of the scalp, later enters the hair follicle, and finally attacks the superficial or deep parts of the hair, gradually working up the shaft, which becomes very brittle and later breaks into small and frequently minute pieces, which, when the hair is dry, are easily projected and scatter in all directions. Since both the Microsporum audouini and the Microsporum lanosum form a mosaic sheath around the infected hairs, which is made up of numerous small spores, these scattered particles of broken hairs constitute an ideal medium for direct and indirect contact spread of the infection. Large numbers of these infected particles are found in caps, scattered throughout the uninfected hair, on the face and neck, and on the collars and coats of infected children. They are easily attracted to brushes, combs and other objects coming into direct contact with them and may easily contaminate barbers' clippers. This dissemination phenomenon is readily and strikingly observed under filtered ultraviolet rays. One of the best demonstrations observed was the case of a 9-year-old boy who was literally covered with hundreds of minute, sparkling, green, fluorescent particles on his hair, face, neck and shoulders. His mother brought with him 2 infants whom the boy had been carrying. Both babies were literally showered on face, hair, eyebrows and neck with hundreds of these infected particles deposited by direct contact with their brother, and an initial ringworm lesion of the scalp was just starting on one infant. The second example of a visible demonstration of contact transmission occurred when an infected child leaned his head against the glass filter of the ultraviolet lamp, leaving a smudge of hundreds of minute, green, infected particles sparkling on the face of the filter. The same transference is possible where the child leans against the back of a seat in the theater or other point of common contact or where heads of 2 children touch in personal contact during play.

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* Read before the Society, November 28, 1945.

It is believed that the principal channel of transmission in the present epidemic is the unsterilized barbers' electric clippers. The recent research work on the subject has been done by members of the United States Public Health Service, who are fully convinced that this is the case. The Microsporum lanosum is an animal type of infection and is acquired originally from contact with infected kittens or puppies, but this too may be spread through other channels.

USE OF FILTERED ULTRAVIOLET RAYS

The use of the filtered ultraviolet rays produced by the use of the "Wood" filter, which passes wave lengths in the near portion of the ultraviolet part of the spectrum in the region of 3,650 Ångström units, is a necessity in the diagnosis and treatment of this disease. It aids in the diagnosis, the follow-up of the progress, the success of treatment, and in determining when cure has taken place. It also searches out small patches of infection impossible of discovery in daylight or incandescent light and serves as a guide to the areas requiring topical or other treatment. It is advisable to recheck frequently cases being given topical treatment to discover overlooked or new areas of infection which may exist. It is also of importance to know that research has shown that as long as there is green fluorescence present in the hair, the infection is still alive and communicable.

The majority of the common species causing ringworm fluoresce a light, yellowish-green color under filtered ultraviolet rays. In all Microsporum infections, except one, the hairs fluoresce green. In many of the Trichophyton species the hairs are dull or bluish. Some of the trichophyta have varying different fluorescent characteristics. Cultures of these organisms may also be identified by their individual characteristic fluorescence. The fluorescent property is so striking that every infected hair is easily differentiated from the normal in the most frequent types of infection, and even when the same organism invades the glabrous skin and causes a typical ring-shaped lesion, the lanugo hairs can be seen as minute green dots where these hairs have fractured at the skin surface.

Many organic and inorganic substances also fluoresce; teeth, and keratin in nails and palms of hands both fluoresce brilliantly. Lipstick gives a brilliant orange fluorescence, and petrolatum fluoresces purple. Salicylic acid and many other drugs give characteristic fluorescence and may mask the infected hair. All treatment should be removed before examination by the Wood light.

For thorough examination, diagnosis and guide to treatments, the filtered ultraviolet rays should not be depended upon exclusively, but other methods including direct microscopic examination, trichophyton test, cultural methods, etc., should be used and should become routine for all fungus infections.

CLINICAL SYMPTOMS

Ringworm of the scalp is characterized by a loss of luster, loosening, brittleness, breaking off and partial loss of hair in patches, mainly in children under puberty. Epidemic ringworm of the scalp is rarely found in adults, but ring forms on the glabrous skin from lanosum infection frequently occur in adults. The skin infection may occur in adults including the mother as well as other children. In boys the original lesions are most frequent in the occipital region and in areas where the short hair is shingled with the clippers at the back and sides. In girls the original lesions are most frequent where the scalp is most exposed at the whorl just above the occiput or in the part of the hair on top or in the back. Original lesions may increase in size, and subsequently new patches of infection may occur. In many cases, however, no secondary areas develop. Lanosum infection is more likely to be inflammatory in character and to cause simultaneous lesions on the glabrous skin. Both audouini and lanosum infections usually cause gray, scaly patches on the scalp under the area of the infected hair. Occasionally marked, boggy, painful swelling and inflammation may occur due to any species of ringworm infection. This is called kerion, and when much inflammation is present, the inflammatory condition is likely to bring about eradication of the infection when healing is completed. In general, patchy loss of hair from a child's scalp denotes ringworm until repeated laboratory investigation fails to confirm the diagnosis.

PREVENTION

To conserve time, preventive measures will be listed only.

1. Detection of infected scalps by use of filtered ultraviolet rays before admission to school or institution.
2. Requirement of higher standards of barbershop technic, including sterilizing of electric and hand clippers, scissors, combs and brushes for each patron, especially for children under 16. (NOTE: Electric clippers with easily removable heads are preferred to other types. Dipping of clipper heads into boiling mineral oil for 2 minutes will sterilize without rusting.)
3. During emergency epidemic prevalence of ringworm, avoidance of use of unsterilized clippers for children under 16.
4. During epidemic prevalence, use of fungicidal ointment followed by shampoo of the hair promptly following having children's hair cut.
5. Avoidance of contact with kittens or puppies having infected patches of thin or bald fur. (NOTE: Filtered ultraviolet rays should be used to examine pets for ringworm.)
6. Avoidance of contact of children's heads with backs of seats in theaters.
7. Routine repeated examinations of all children contacts in the family with filtered ultraviolet rays.
8. Restriction of infected cases:
    a. Avoidance of movies, barber shops, children's camps, and actual contact in playing with other children.
    b. Exclusion from school until treatment is thoroughly initiated. Permission to be granted to return to school provided close fitting (stocking) caps sterilized by boiling 5 to 10 minutes daily be worn constantly and at home day and night until the disease is eradicated.
    c. Patient to use only his own comb, brush, hat or cap, and to sleep alone.

TREATMENT

Some types of scalp ringworm infection are more easily cured than others. Infections pathogenic to animals may be quickly cured and recovery may be spontaneous. Infections not pathogenic to animals are as a rule more resistant to treatment, and if unsuccessfully treated remain for an indefinite period. Audouini and lanosum infections are usually mild and tend to clear up spontaneously about puberty. The rarer trichophyta usually produce infections which are either severely inflammatory or

(Continued on page 97)

President's Page

THE HALFWAY MARK

My term as President of the District of Columbia Medical Society is half over, and as I have stated on several occasions, it has been an enjoyable experience. It was a real adventure getting the over-all picture of the Society and seeing how varied were the activities of the different committees and the amount of work that is turned out at 1718 M Street.

Everyone has been most coöperative and kind. I have enjoyed getting to know more of the members. The Executive Board each month has an agenda that takes real plodding for about three hours to finish. Our general Secretary, Ted Wiprud, is the pin that holds us all together. He is not only interested in the Society and all its members but he is terribly in earnest and eager to see medical care in this country go to the highest possible level. This voluntary plan for prepaid medical care for those in the lower income brackets is his great dream. If it proves successful here and in other areas he hopes it will eventually become national in scope. I am under the impression that he has done more than any other man to get the House of Delegates of the A.M.A. to come out with a real national health program. He will probably modestly deny this, but I feel sure it is so. I have been increasingly conscious of how much thought and effort he gives to the Society.

There are many men in the Society that give much the same effort and thought to it, and that is why it is a real going concern.

At this time I do want to say how very sorry we are that members returning from the armed services have had such difficulty finding office space. Dr. Lahey tells me they have the same difficulty in Boston. The Committee on Returning Veterans and Mr. Wiprud have labored increasingly, but only about 25 per cent of the men have been able to secure offices so far. I hope by the time this number of the ANNALS comes out there will be a change for the better.

Finally, I want to thank Dr. Oscar Hunter and his Program Committee for the excellent programs they have given us. It was thrilling to hear Dr. Lahey, both on thyroid disease and on state medicine. He is a great leader and we are grateful for his message.

Thanks again everybody.

Wm. Earl Clark

Editorials

PREPAYMENT MEDICAL PLAN PRESENTED

Before these lines appear, members of the Society will have become familiar with the prepayment medical plan developed by the Committee on Medical Care to be known as MEDICAL SERVICE OF THE DISTRICT OF COLUMBIA. It had been previously announced that the plan would first be submitted to physicians in the armed forces for their consideration. However, so many of them had returned that it was decided to mail it to all members of the Society at the same time.

A communication directed to the membership was enclosed with the folder describing the proposed plan together with a form on which to indicate whether or not the member wished to become a participating physician. The Committee impressed upon physicians the urgent necessity for every member of the Society to underwrite the SERVICE. In addition, it was emphasized that all who agree to participate must wholeheartedly support the undertaking if it is to succeed.

Some may wonder why it has taken the Medical Society so long to develop its prepayment plan. Many things have slowed up the work on it. For example, several studies were made of other plans operating successfully; statistical research was necessary to determine a sound basis on which to operate; and negotiations had to be carried on over a long period of time with Group Hospitalization, Inc. As members will recall, it is contemplated that Group Hospitalization will administer the business affairs of the SERVICE if it is approved by the membership.

There will undoubtedly be objections raised in some quarters to the fact that MEDICAL SERVICE is a limited plan and not inclusive enough. However, the Committee has ascertained that limited prepayment plans are the only ones which have succeeded thus far. It is their hope that when the plan has been sufficiently stabilized it will be possible to include additional benefits. The Committee believes it wise to proceed slowly. As experience is gained, weaknesses will be eliminated and a sound basis for operation on an expanded scale developed.

Another point which will be a source of discussion among physicians is the matter of income levels. There are none in this plan. However, there are restrictions which will make it possible for participating physicians to charge those who demand more than ordinary hospital facilities fees which they believe to be commensurate with their ability to pay. This provision in the plan should be read carefully by physicians.

It is expected that the vote for this plan will be preponderantly favorable. In the opinion of the Committee, this will be the final opportunity for the Medical Society to offer a prepayment plan acceptable not only to Group Hospitalization, Inc., but to the people of this community. An appeal is therefore made here to all members to register their views with respect to the plan promptly. There is no time now for delay. This is the most important step contemplated by the Society in a very critical period in its history.

T. W.

ARMED FORCES RETURN BLOOD PLASMA

A carload of 5,604 packages of dried blood plasma, declared surplus by the Army and Navy, is being distributed without cost to the people of the District of Columbia through hospitals and licensed physicians and surgeons. The American Red Cross has transferred the plasma to the local Health Department as part of a plan of national distribution. The plan of distribution through State Health Officers has been approved by the Association of State and Territorial Health Officers, the American Medical Association and the American Hospital Association. This first shipment is an estimated six months' supply for the District.

The provisions under which the surplus dried plasma is being returned to the American people by the armed forces through the American Red Cross are contained under Public Law 457 of the 78th Congress dated October 3, 1944 which reads:

> "No surplus property which was processed, produced or donated by the American Red Cross for any government agency, shall be disposed of, except after such notice to and consultation with the American Red Cross. All or any portion of such property may be donated to the American Red Cross, upon its request, *solely for charitable purposes*."

The medical profession has an obligation in using the plasma in the same spirit in which the people gave their blood for a long war which was fortunately terminated sooner than was expected.

The District of Columbia Health Department has issued instructions concerning the handling and care of the plasma. It should be understood that the plasma will be distributed free of charge to all patients regardless of income. However, hospitals and physicians may charge for services rendered in administering the plasma. Each package contains "report on use" forms. These are to be disregarded except when physicians may wish to employ them for their own purposes. Please do not send these "report on use" forms to the Army or Navy.

As to storage, the plasma must be kept in a dry place with a temperature range between 35° F. and 100° F. Avoid freezing temperature. In order to obtain supplemental supplies of blood plasma all that is necessary is to present a letter to the District of Columbia Health Department, Property and Supply Officer, Room 6149, New Municipal Building, 300 Indiana Avenue, N.W. Each package of the plasma is stamped as follows:

> *This package of plasma, having been declared surplus to the needs of the armed forces of the United States, is made available through the American Red Cross for civilian use.*
>
> NO CHARGE SHALL BE MADE FOR THIS PRODUCT
>
> *Distributed by*
>
> D. C. Health Department
> Property & Supply Office
> Room 6149, East Administration Bldg.
> 300 Indiana Ave., N.W.
> Washington, D. C.

So far, 17 hospitals in the District have been given supplies of plasma by the Health Department. A reserve supply is on hand for use of private physicians and surgeons. The American Red Cross will issue the Health Department additional supplies when needed.

The District Health Department asks the medical profession to assume responsibility in carrying out its obligation in making available this excess plasma so that it is made freely accessible to the citizens of the District of Columbia.

For purposes of determining future needs and uses of the plasma, the Health Department would appreciate reports from physicians and surgeons on their experiences and observations in dealing with the plasma.

GEORGE C. RUHLAND, M.D.
Health Officer

PRESENT STATUS OF TREATMENT OF SUBACUTE BACTERIAL ENDOCARDITIS

Before the advent of sulfonamide therapy subacute bacterial endocarditis was almost uniformly fatal. This is amply substantiated by the report of Kelson and White[1] of 250 cases studied prior to 1939. In this series 246 patients were adequately followed up, and all died of the disease except one. In the exceptional case death was due to rheumatic myocarditis, but the autopsy left some doubt as to whether or not the patient had ever had subacute bacterial endocarditis.

The use of sulfonamides in the treatment of the disease changed this picture, but not much. Sulfonamide therapy alone or in combination with heparin induced hyperpyrexia, or typhoid vaccine accounted for cures in 4.5 to 15 per cent of cases.[2]

Early reports on the use of penicillin for subacute bacterial endocarditis were strongly discouraging. In January, 1944 White summed up the experience to that time by stating that penicillin had been tried in small doses and found ineffective. He awaited the results of larger doses "without much optimism."[3] However, as little as 2 months later he had decided that the awaited results were "quite encouraging."[4]

In the 2 years that have since elapsed enough evidence has accumulated to convince the most conserative student of the problem that a large majority of patients with subacute bacterial endocarditis can be cured with penicillin. In the light of similar conquests of other infectious diseases this is not unusual, but it is no less remarkable. The development of technics for the treatment of subacute bacterial endocarditis with penicillin has been so rapid that a review of our present position seems justified.

Almost all cases of subacute bacterial endocarditis are caused by the Streptococcus viridans, but not all strains of this organism are equally susceptible to penicillin. Under ideal conditions the sensitivity of the causative organism to penicillin should be appraised in vitro before therapy is started. The information obtained by this means provides some basis for decision as to the size of the dose. Under any circumstances the total daily dose of penicillin should be at least 200,000 units.[5] Amounts up to 5 times this figure may be needed to cope with a "resistant" organism. Providing that the daily dose is large enough it appears to make little difference whether penicillin is given by continuous intravenous or intramuscular infusion or by intermittent intramuscular injections. When this last technic is used the intervals between doses preferably should be short (2 or 3 hours). Investigation of methods which may make it possible to lengthen the intervals between injections[6] has not yet been reported in connection with this disease. The case of Burke et al[7] in which oral administration of penicillin was effective will undoubtedly stimulate others to explore this technic, which at present is certainly not adapted to general use.

Regardless of the method of administration, recent reports[8, 9] make it very clear that uniformly successful results in the treatment of subacute bacterial endocarditis are best assured by giving penicillin for a long time (probably at least 2 months). While it is true that 2 or 3 weeks of treatment may be enough for cure in some cases, others will show relapse after such a short course. Hirsh and Dowling[9] have pointed out the disadvantages of a régime in which relapses prevail. The chance of complications is increased, the cost of treatment in 2 "short" courses is usually more than in 1 "long" course, and the development of resistance by the organism to penicillin is more likely to occur.

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[1] Kelson, S. R., and White, P. D.: Ann. Int. Med., 1945, **22**, 40.

[2] Paullin, J. E., and McLoughlin, C. J.: Ibid., 1945, **22**, 475.

[3] White, P. D.: Heart Disease. New York: Macmillan, 1944, p. 369.

[4] White, P. D.: Ibid., p. 973.

[5] Keefer, C. S., Herwick, R. P., Van Winkle, W., and Putnam, L. E.: J. A. M. A., 1945, **128**, 1161.

[6] Hussey, H. H.: M. Ann. District of Columbia, 1945, **14**, 24.

[7] Burke, F. G., Ross, S., Walsh, B. J., and McLendon, P. A.: Ibid., 1946, **15**, 22.

[8] Bloomfield, A. L., and Halpern, R. M.: J. A. M. A., 1945, **129**, 1135.

[9] Hirsh, H. L., and Dowling, H. F.: South. M. J., 1946, **39**, 55.

With ideas in mind that have previously been commented upon in the ANNALS,[10,11] heparin has been employed by some investigators as an adjuvant to penicillin therapy. This combination of drugs apparently has no advantage over penicillin alone in the treatment of subacute bacterial endocarditis.[12]

Now that bacterial endocarditis is curable some authors[8,13] have shown increasing interest in certain complications of the disease, especially cerebral embolism, acute rheumatic infection, and congestive heart failure. As a matter of fact, the incidence of heart failure in subacute bacterial endocarditis has been increased by the cure, for two reasons. First, the opportunity for development of heart failure as a result of the underlying rheumatic or congenital cardiac defect increases in proportion to the length of survival; and second, it seems probable that additional valvular damage is often created by the process of healing of the endocarditis.[8]

Because penicillin is so amazingly effective in curing various infections and is itself so innocuous, there is great tendency to use it indiscriminately. In this connection, Flippin and his co-workers[14] have emphasized the importance of establishing a diagnosis before starting penicillin. Violation of this practice in cases of bacterial endocarditis is dangerous chiefly because a little penicillin may alter the clinical picture without effecting a cure. The resulting delay in diagnosis is undesirable in any case and may be disastrous in some.

H. H. H.

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[10] Hussey, H. H.: M. Ann. District of Columbia, 1939, **8**, 370.

[11] Hussey, H. H.: Ibid., 1942, **11**, 446.

[12] Keefer, C. S.: Am. J. M. Sc., 1945, **210**, 147.

[13] White, P. D., Matthews, M. W., and Evans, E.: Ann. Int. Med., 1945, **22**, 61.

[14] Flippin, H. F., Mayock, R. L., Murphy, F. D., and Wolferth, C. C.: J. A. M. A., 1945, **129**, 841.

In and Out of Focus

BY THE OBSERVER

V.A. Bill Becomes a Law

Last minute efforts by the Civil Service Commission and Budget Bureau officials to kill a bill which would establish a Department of Medicine and Surgery in the Veterans' Administration were successfully defeated when the President's signature made it a law on January 3. It had been reported in the Washington press a day or so previously that General Omar Bradley, Administrator of Veterans' Affairs, and Major General Paul R. Hawley, Acting Surgeon General, were ready to relinquish their posts if the President should veto the legislation.

Immediately upon signing the bill, the President addressed a letter to General Bradley in which he said:

> "It is my desire that, in carrying out the provisions of this law, you develop a system of recruitment and placement which will grant priority to qualified veterans and which will also provide against any possibility of discrimination because of race or creed.
>
> "I hope that this legislation will enable you and your associates to move forward in your determination to provide the veterans of this country with a progressive up-to-date department of medicine and surgery. Much progress has been made in this direction, and I shall watch with real interest any additional steps which will be taken by you under this new law."

In commenting on the President's action, *The Washington Post* observed that General Bradley can now:

> "1. . . . remove incompetents even when they are veterans of World War I, without having to battle through a virtual jungle of red tape.
>
> 2. . . . rebuild the medical services without the stigma of low standards which, justly or not, has been marked against civil service by the medical profession."

General Hawley, highly pleased, said, "Our objective is clear—a medical service for the veteran that is second to none in the world. Around the splendid nucleus of excellent men and women in the V.A. medical service, we shall build such an outstanding service."

According to the General, the Veterans' Administration is short 1,125 physicians, 1,200 nurses, and 100 dentists; many V.A. hospitals are operating with half staff, although the patient load has increased to an all-time high of 90,000 and is steadily increasing.

Editorial comment in the Washington press was uniformly favorable. "The advantages which wounded and ailing veterans are expected to derive from the new plan," said *The Sunday Star* (January 6, 1946), "would seem to justify, in this instance, a departure from civil service restrictions, provided the presidential directive regarding preference for veterans and antidiscrimination safeguards is rigidly adhered to."

The *Post* on January 8 editorialized,

> "The perturbation felt by defenders of the civil service system over the abandonment of civil service requirements for the new agency is altogether understandable. We do not think that the disrepute into which the Veterans' Administration has fallen is attributable so much to civil service regulations as to ineptitude on the part of the particular administrative officials responsible for VA personnel. But the fact is that a general housecleaning of the doctors in the VA has now become necessary. And it will be easier to accomplish without civil service restrictions than with them. Once the necessary reorganization has been accomplished, however, General Bradley would do well, we think, to ask Congress to blanket the new personnel into civil service, for their own protection no less than for maintenance of the merit system."

General Bradley was interviewed by Charles Hurd of the *New York Times* on January 10. He spoke frankly on the care of veterans and of his intentions to build up an adequate medical staff. "We want to keep and make jobs more attractive for all the good men we have got," General Bradley emphasized. "I do not want to give the impression we are filled up with incompetent doctors; we are not. We have got a lot of good doctors." General Bradley made it clear that the weeding-out process was to be made by freshly appointed men so that older doctors in the V.A. service would not be embarrassed by having to pass judgment on their colleagues. He said that relatively few of the V.A. staff would be fired, but some apparently have been reported as doing more harm than good. The General did not expect to be able to recruit the total of 5,000 he considers necessary, but he does expect to obtain a considerable portion of that number because of improved professional working conditions and compensation. He said the pay alone was not an inducement to the better type of doctor but that the top specialist rate which V.A. now might pay, $11,000, was equivalent to $18,000 earned in private practice. The average compensation for a V.A. physician is $5,500, which the General said was equivalent to $10,000 or $11,000 a year in private practice.

One of the greatest advantages of the new law, he explained, was the authorization given to classify doctors entering the veterans' hospitals "on the personal basis of professional experience rather than on the basis of jobs which might be open at the time the doctors were employed."

From all this it appears that the Veterans' Administration is entering upon a new and a better era.

★

"No Threat... but a Great Opportunity"

The new Federal Security Administrator, Watson B. Miller, is a friendly man who is kindly disposed toward the medical profession. It is not surprising then that he was favorably looked upon by physicians as a successor to Paul V. McNutt. In fact, they supported his appointment vigorously.

Naturally the medical profession was anxious to learn Mr. Miller's views with respect to pending social security legislation. They were not kept in the dark very long for he discussed them at some length at a meeting of the Medical Society of the County of New York on December 17, 1945.

"I am neither an economist nor a physician nor a Daniel come to judgment," Mr. Miller told New York physicians. "Yet I do share your active concern not only for the people's health and for the unique and irreplaceable contribution of the Nation's doctors to our common welfare, but also for the complex social and economic setting in which people, including doctors, today live and move and have their being."

For the remainder of his address, Mr. Miller had much praise and practically no censure for the medical profession. As might have been expected, he stood firmly by the President, arguing persuasively for compulsory health insurance. Being the kind of man he is, he trod as lightly on medical toes as possible. But the fact remains that he does not stand with organized medicine on this vital issue.

"The President proposes," Mr. Miller observes, "that we apply what Winston Churchill has called 'the magic of averages' not only to wage loss, but also to payment for medical care. This proposal is neither so new nor so revolutionary as some of the comment on it implies. Every State but one already has such a system of health insurance in operation—for workmen's compensation is health insurance, and the major difference between this long-standing program and that proposed by the President is that it covers only on-the-job accidents and illnesses, whereas the proposed plan would cover nonoccupational accidents and illness. No one seems to question that, even with the inadequacies inherent in any partial plan, workmen's compensation is a benefit both to the worker and the physician. A broader plan would assure better care to more people and more adequate compensation to the doctors and hospitals who serve them.

"Without going into legislative and technical details which are properly a concern of the Congress, I want to review with you some of the fundamental issues involved in this proposal. The most frequent is simply 'Why?—Why can't ordinarily self-supporting families pay their own doctor bills?'

"The plain fact is that they haven't got the kind of money it takes to meet the cost of medical care, either on the emergency basis of a sudden, catastrophic and costly disaster, or on a long-time basis of continuing prevention.

"Ten years ago, when the last comprehensive survey was made, more than 92 per cent of the people in this country were in families that had an income of less than $3,000. Even with the upswing since that time, the majority of people in this country still have less than $3,000, and as we all know, a dollar doesn't go as far today as it did ten years ago. Dr. Leland, former Director of the Bureau of Medical Economics of the AMA, is authority for the statement that an income of less than $3,000 a year provides no safeguards against medical indigence when costly or prolonged illness strikes. Putting these two facts together, we cannot escape the conclusion that all but a tiny fraction of our people live below this margin of safety.

"Granting that we must spread the cost of medical care, why can't the individual obtain his own insurance? Hard facts again spell the answer. Most of us cannot afford to pay the full insurance premium. Even those who are normally self-supporting have immediate wants which seem to outweigh possible future costs that human optimism always hopes may not actually occur.

"True, many people do carry hospital or medical care insurance. The Blue Cross movement, in particular, has shown remarkable progress in the last ten years. But even so, it covers less than 13 per cent of our entire population, and is made up chiefly of city people in the middle income brackets. All told, perhaps 40 million persons have some such protection through private insurance. Its adequacy is in some cases another question. Further, this is too often just another instance of the old saying that 'them as has, gets'—those who least need this protection are best able to afford it. And those who experience more frequent and more serious illnesses cannot afford it. Public opinion polls show that something like 30 or 40 per cent of the people in this country put off going to the doctor because it costs money.

"Voluntary insurance, significant as it is, thus does not provide a complete or adequate answer. Many State medical societies have worked hard to set up systems for prepayment of medical care. These plans represent an earnest attempt on the part of organized medical groups to spread the costs. Though they have encountered great difficulties, several of these plans have had considerable success. One of their major problems has been the hazard of adverse selection. Any prepayment plan which people can enter and leave at will is subject to this handicap. But a general social insurance system obviates the possibility of adverse selection because it covers the good risks as well as the bad."

Having disposed of voluntary insurance as being impractical, Mr. Miller argues as follows:

> "Professional control over medical practice is an ancient prerogative—older than the Hippocratic Oath. The guidance, the direction, the supervision, the discipline of doctors are primarily matters for doctors to handle. Subject to Government regulation through licensure, the responsibility has always been yours and should remain so. But just as public licensure gave the profession a new opportunity to deal with these problems, just as grading of medical schools, registration of hospitals, administration of workmen's compensation, and establishment of voluntary insurance plans—to mention only a few—have given you new opportunities to exercise professional controls, so health insurance would constitute still another advance in the long evolutionary movement for high ethical and qualitative standards. On this broad question, health insurance presents no threat—but a new, great opportunity."

Although organized medicine cannot go all the way with Mr. Miller, your Observer feels certain that it has in him an understanding friend. And at this moment there are not too many of them in the Nation's Capital.

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National Health Congress

As the conflict over the regimentation of physicians increases in intensity, so the proposals to meet this issue multiply. The Michigan Medical Society, which is never at a loss for ideas and, incidentally, some very good ones, now comes up with the National Health Congress. Its proposal was submitted to the Conference of Presidents and Other Officers of State Medical Societies held immediately preceding sessions of the House of Delegates of the American Medical Association last December. The response at that time seemed to your Observer to be none too enthusiastic. However, the program is certainly worthy of consideration.

In an article urging the immediate organization of the Congress appearing in the October 1945 issue of *The Modern Hospital,* the following observations are made:

> "The accomplishments of those concerned with safeguarding the physical well-being of the American public have received far too little attention. Headlines about the extension of the Social Security Act to cover the health needs of all people regularly make the front pages of our big daily newspapers, but the increase of nearly fifteen years in the average life span through disease control and improved surgery, being a statistical fact, usually appears in smaller type on the financial pages of the same newspapers or as a dull article in our higher level magazines.
>
> "The scientific improvements in public health contributed by private sources, the steady and encouraging extension of voluntary prepaid protection, as exemplified by the increase in Blue Cross membership, are constantly being pushed out of the spotlight by the proclamations of those who would force John Q. Public to be full of health whether he is interested in being healthier or not."
>
> "What can professional people in the health field do about it? What will they do about it? Certainly, it is obvious that if the voluntary forces in this country do nothing about it they will lose, and the country will also lose, by default . . . and for this reason we propose the National Health Congress."

As to the proposed organization's structure, the article states:

> "The National Health Congress is envisioned as a national organization patterned after our national legislative congress. As proposed, it would be not merely an organization providing a public forum for the discussion of health practices and objectives, but a legislative body created by the voluntary health forces and endowed with the power to act for them."

It is contemplated that the Congress membership shall be made up of a representative or representatives of each state hospital association, state medical association, state dental association, state nursing association, state pharmaceutical association, the industry of each state, the labor of each state, the agriculture of each state, a representative of the United States

Senate, the House of Representatives, and the United States Public Health Service.

The Congress' objectives are described as follows:

> "1. Extending standard health coverage to all people of any economic status wherever located.
>
> "2. Extending facilities and research projects necessary to further the improvement of health standards of the nation.
>
> "3. Evolving a sensible prepayment method, covering all items of health care on an economical cost basis for the individual or family unit.
>
> "4. Studying and recommending to the federal and all state governments their proper and most productive participation in the health activities of the nation and the states, particularly the endowment of greater research projects, and the extension of benefits to the indigent and public wards.
>
> "5. Empowering a national health administration under its control to carry out its directives."

Foreseeing objections to such an ambitious program, proponents of the Congress say, "There may be some who will contend that this proposal is too big, that it would be impossible to accomplish. To these individuals we should like to make just two observations.

> "The first of these is that all projects that have brought great benefit to great numbers of people have been thought of by a portion of those concerned as impossible of accomplishment. Medicine and surgery alone offer numerous examples.
>
> "The second observation is that there is no other alternative within the time remaining for action by nongovernmental forces. If, however, the American people were shown some disposition on the part of the health professions to offer a program that promised a better solution under private control, the public might have some reason to wait—the government would have less reason to label health extension 'must' legislation and to push it vigorously.
>
> "There may be those who will question the advisability of giving membership in the congress to industry, to labor and to agriculture. Broadly speaking, these three groups are the public of the professional people. It's not only your health but their health which is under consideration. They have a right to be heard and to have a hand in shaping the perfect national health plan. If the health professions fail to give it to them, labor, at least, will feel that it can get it from the government."

The statement concludes with the admission that while the Congress "is still in swaddling clothes, it needs only the interest, care and guidance of the professions to grow quickly into a lusty youngster with a sparkling future."

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"*. . . It Has Its Points*" Many doctors become apoplectic at the mention of the Wagner-Murray-Dingell bill. They see absolutely no merit in this legislation. However, there are those who are more moderate in this respect. One of these is Dr. J. W. Jervey, Jr., of Greenville, South Carolina, who, in an address to the Section on Ophthalmology and Otolaryngology of the Southern Medical Association last November, said:

> "If proposed legislation has done nothing else it has made the medical profession sit up and take notice of needs in general as regards medical care. We must all assume the obligations and take advantage of the privileges which we knew were to be ours when we undertook the study of medicine. Reference here is to the entirely inadequate care of the indigent in well organized communities where all too frequently busy practitioners are unwilling to give of their time and experience to clinic work. This is not hearsay, but an indictment brought as the result of personal knowledge. The aim of the government is to furnish adequate medical care. The challenge to our profession is to meet the need without the necessity for coercion. Much thought has been given to this matter, and plans abound. Many of them are good. My beloved state of South Carolina has come forward with a ten-point program which has received national attention and commendation.
>
> "There was much argument last year over the Wagner-Murray Bill. There will be much again this year over Senate Bill No. 1050. Yet how many of the physicians who argue so loudly are accurately informed as to the contents of these bills? To begin with there is nothing in S. 1050 that remotely attempts to force anything upon physicians nor are all of its objectives wholly diabolical. On the contrary there are many things in the Wagner-Murray-Dingell Bill which are exceedingly desirable and therefore commendable. Surely we are in need of better and greatly extended health services, better housing and sanitation, and better hospital facilities. That is not to say that passage as it now stands is advocated, but it has its points.
>
> "As I see it, beyond the deplorable fact that it will

further increase taxes, there are three main objections to the bill. The most important of these is that there is in it absolutely no provision for the care of the indigent between the ages of 18 and 65 years. . . . If proponents of the bill care to argue it was intended that the privilege of caring for the poor be left as heretofore with local institutions and physicians, then the care of those who can pay might well be left there also."

"The second objection is that medical insurance is placed on a compulsory and not on a voluntary basis. Very sensibly the federal government offered a life insurance policy to soldiers and sailors in service, but also very wisely they were not required to take it. Why then should a man be forced to take out a medical insurance policy he does not want? For the good of the whole? Impossible, for the indigent are not provided for and only those who have jobs may receive benefits.

"Thirdly, contrary to Mr. Wagner's assurances, there is in the bill definite restriction on the choice of physician by the patient, and he may have to pay more than he should to obtain the service he desires. For example, John Jones is a patient of yours. Rightly or wrongly he believes that you are the 'best doctor in the whole United States.' You do not take on this government work, but when little Johnny gets sick his father wants you to take care of him and pays for it. Mr. Jones has been forced to pay twice, once from his pay envelope for something he did not want and would not have, and again from his purse for the service desired and obtained.

"Furthermore, by the terms of this bill you as a specialist can be consulted only by request of the patient's family physician! He will be loath to give up his small fee in your favor and will more often than he does today unfortunately try more and more to manage conditions the best treatment for which he is not in a position to know."

Dr. Jervey then gives some sound advice.

"How shall we attack it? First we must think clearly and carefully about it, and each must lend an idea or hand where possible in its solution. In addition we must keep cool and not jump frantically to false conclusions as to what somebody is trying to do to the medical profession. Rather we should give much thought and attention to what the medical profession is doing to itself."

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In Accord But—

No organization has taken a more objective view of the troubled medical scene than the New York Academy of Medicine. It is fair to state that it is also further advanced in its social thinking than any other medical organization in the country. Liberal though its outlook, it recently turned thumbs down on compulsory health insurance. Dr. George Baehr, the Academy's new President, on January 3 presented a statement formulated by his organization's Committee on Medicine and the Changing Order in which its position was made clear. The Committee's three-year study and recommendations will be published in the form of a final report this year.

With respect to President Truman's health message, the Academy felt "impelled to make its views public at this time." Although the Academy opposed a national compulsory scheme of medical care proposed by the President, it offered eight recommendations. They appear here as they were published in the *New York Times*.

"(1) That voluntary, non-profit insurance receive a thorough trial as a means of providing medical services for low-income families.

"(2) That in certain instances, and particularly when private resources are inadequate, Government support be provided.

"(3) That careful experiments be conducted 'at State and local levels with compulsory insurance, so that we may have in the near future comparative experience with the relative values of voluntary and compulsory procedure.'

"(4) That better opportunities for continued medical education, whether graduate or postgraduate, be provided in order that requirements of newer medical services may be met.

"(5) That there be a gradual extension of group practice in close coöperation with high grade hospitals.

"(6) That special emphasis be placed on preventive medicine in all forms of practice.

"(7) That basic public health services be provided for those communities that now lack them.

"(8) That provision be made for the education of the public in order that it may better know how to obtain treatment and coöperate in the prevention of disease."

Endorsed were the President's recommendations for the construction of hospitals and related medical facilities, the expansion of public health, maternal and child health services, the advancement and support of the Federal Government of medical education and research, and the protection of workers against loss of wages resulting from sickness and disability. The Academy warned, however, that the medical problems could not be solved simply by erecting structures and creating physical facilities. It directed attention to the shortage of medical and other personnel, emphasizing the point that there is no assurance that they will be obtainable in the near future. The great need, as the Academy sees it, is to train young physicians, many of whom have served with the armed forces, so that they will be adequately equipped to render the best medical service.

The *New York Times* was surprisingly sympathetic to the Academy's stand.

> "The danger of political influence cannot be dismissed," the *Times* said, "although the British experience indicates that this is not as black as it is often painted. What must be stressed is the poor quality of medical care that has been given under compulsory insurance plans. The quality of medical care is of prime importance and must be emphasized."

The real surprise was the *Times'* views on prepayment medicine.

> "Dubious as the outlook for voluntary insurance may be," the *Times* said, "it is possible that the American Medical Association, in accordance with resolutions recently passed by its House of Delegates, may evolve a system which will work. However, time is of the essence. We cannot wait for 'a variety of study and experimentation conducted at local levels.' The need for a broad health insurance program is now. The coverage must be comprehensive and the scope national. Such a program must be started at once, but could be modified as research and experience dictated.
>
> "Many county and State medical societies are already operating successful voluntary health insurance programs. The Michigan plan with 800,000 members, for example, has operated most successfully for the past three years. Cannot a national voluntary insurance plan be started at once, using these experiences as a background? A national voluntary insurance plan combined with an aggressive educational program has many advantages over the compulsory type, but we cannot wait years for such a program. We are in the position of the patient to whom a radical surgical operation has been recommended. He asks for consultation and the consulting physician disagrees with such radical procedure and recommends a broad research program in this particular disease. This is a sound scientific suggestion, but the patient may die in the meantime.
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> "If organized medicine feels that compulsory health insurance is not the answer to this admittedly pressing problem, organized medicine must supply the answer. By utilizing the experience of existing voluntary medical and hospitalization plans, with grants-in-aid for the indigent and low-income groups, and with bold leadership, a satisfactory national voluntary program could be achieved."

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Our Combat Losses—World War II "The surrender of Japan last August brought to an end the costliest war both in terms of life and treasure that this country has ever fought." Thus, in its November, 1945 issue the *Statistical Bulletin* published by the Metropolitan Life Insurance Company sums up the recently concluded conflict. It estimates that the death losses in our armed forces will exceed or come close to 325,000 "when allowance is made for deaths among those wounded in action, and for the numbers still carried as missing, who eventually will have to be written off as killed in combat or died as a result of enemy action."

Emphasizing the magnitude of the war, the *Bulletin* continues:

> "Our combat toll in World War II was thus more than six times as high as that in World War I. Our losses in World War II can be gauged by the fact that they far exceed all our combat death losses in all previous wars in which we have engaged, including the losses of both sides in the Civil War. The aggregate of all American losses in previous wars was barely a quarter of a million.
>
> "Of our total combat losses in the war just ended, about four fifths, or between 255,000 and 260,000, were suffered by the Army; the remaining 65,000 to 70,000 were incurred by the Navy, including the Marine Corps and Coast Guard. Of the Navy's total, about 23,000 were Marines, and about 900 Coast Guard men. The higher toll of the Army obviously reflects the much larger numbers of its men who were exposed to combat as compared with the Naval forces. Relative to their strength, however, the combat losses for the two services were more nearly equal.

It may be noted, moreover, that the combat deaths in the Navy (including the Marines) were appreciably greater than the total losses for all our armed forces in World War I. The Navy and Marines together lost more than 20 times as many men in the recent war as they did in the first World War; and the Navy alone, since Pearl Harbor, lost about 100 times more men than in the last war. In fact, the Navy in World War II lost more than ten times as many as in all previous conflicts combined."

The *Bulletin* observes that two thirds of the losses occurred in the West and one third in the Pacific and the Orient. The Army alone lost more than 200,000 men in the European theater, including Italy and North Africa. Navy and Marine losses amounted to about 65,000, approximately 9,000 incurred in the war against Germany. Of the latter, nearly all were Navy personnel, and were lost in the battle with Nazi submarines, in convoy operations in the Atlantic and Mediterranean, and in assisting landing operations in North Africa and Europe. The remaining losses of over 55,000 were sustained in the fight against the Japanese.

During the year 1945, losses in all branches of the service were about 125,000. The final struggle for the German homeland was costly, there being heavy losses in ground fighting and in the air. That year also saw our peak losses in the Pacific area. Army losses were estimated at about 100,000, while the Navy lost 25,000. Navy and Marine losses, it is pointed out, also reached their peak in 1945.

As might be expected, the greatest losses were among infantrymen. This branch of the service, the *Bulletin* says, "not only accounts for the majority of the killed, but its rate of loss is higher than that for the Army as a whole." Although the infantry made up only 20 per cent of the total strength overseas, it suffered 70 per cent of the total casualties in killed, wounded, missing, and prisoners. However, the air force had the highest losses of any major branch in the Army. Death losses in the AAF were 15 per cent of the Army total, and in the West nearly 20 per cent of the total.

While we lost heavily, our high command estimates that the German and Italian dead in the Mediterranean area and on the Western front totaled about 375,000 in land operations while the Japanese losses are estimated at more than 1,200,000. These figures, it is said, are well above the losses suffered by the Allies on the several fronts.

The *Bulletin* concludes with this statement:

"The seriousness of our battle toll since Pearl Harbor is not to be minimized, yet it was actually much less than responsible military leaders predicted early in the war. Naturally the sudden collapse of Japan kept our losses down. It should be realized, too, that we suffered fewer deaths than either of our two major European allies, and much less than either of our two major enemies. Allied victory was achieved before either of these enemy nations was able to launch new and frightful weapons against the continental United States. Consequently, our country was the only major belligerent to escape severe destruction of life or property in its territory. But the very size of our losses should spur our leaders in their every endeavor to develop, in concert with other nations, a permanent world organization for peace."

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International Master Health Plan

"A good many people associate legislation to socialize medicine with the advent of the New Deal. But in this sphere, Franklin D. Roosevelt was no innovator; he was a follower. Plans for socializing medicine throughout the world—one nation at a time—had been drawn up by the International Labour Organisation years before. Mr. Roosevelt was merely the agent who, it was hoped, would implement ILO aims in the United States. He made a good start."

Not a few physicians would take issue with this statement which appears in an article published in the November, 1945 issue of *Medical Economics*. For they are convinced that the New Deal had designs upon the medical profession and would have, if it could have done so, regimented it long ago. Neither is there the slightest doubt in their minds that many of the proposals made originated with the New Deal's Brain Trusters.

But *Medical Economics*, after thorough investigation, proves pretty conclusively that "the Wagner-Murray-Dingell bill . . . was written largely by the International Labour Organisation leaders and that those same leaders are a powerful element in the current campaign for its passage."

Here is the history of the development of the ILO as described in this article.

> "The International Labour Organisation began as a private agency with headquarters in Basel, Switzerland. In 1919, under Part XIII of the Versailles Treaty, it achieved official status as a subsidiary of the League of Nations. Its main office, up until World War II, was in Geneva; now it is in Montreal. Branches are maintained in Washington, D. C., and in other major capitals.
>
> "Original founders of the ILO were the International Association for Labor Legislation and its various national affiliates (e.g., the American Association for Labor Legislation). Other international organizations, with interlocking directorates, lent needed assistance; among these was the International Association for Social Security, which openly advocated the socialization of all phases of human endeavor.
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> "The U. S. Senate, in 1919, specifically withheld the assent of the United States from Part XIII of the Versailles Treaty. Senators at that time were aware of the operation of organizations such as the International Association for Labor Legislation and the International Association for Social Security. They knew that Samuel Gompers, president of the American Federation of Labor, had withdrawn from the American Association for Labor Legislation and had denounced its objectives as un-American. Despite Senatorial skepticism about ILO aims, however, the first officially approved International Labour Conference was held in the Navy Building at Washington, D. C., that same year. Franklin D. Roosevelt, then Under Secretary of the Navy, made the necessary arrangements for the meeting.
>
> "From 1919 until 1934 U. S. participation in the International Labour Conference was through unofficial observers. These observers were among the strategists and labor leaders responsible for the creation of the ILO. World socialization was their aim, socialized medicine being only a small factor in their plans at that time.
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> "In 1934, through an unheralded joint resolution, passed by Congress, the United States became a 'Member State' of the International Labour Organisation and accepted the ILO constitution. But only a small segment of the public knew about it.
>
> "Nor did many realize, as stated in the resolution, that the United States 'took part in 1900 in establishing and for many years thereafter supported the International Association for Labor Legislation.' Thus, world planning for compulsory social insurance is directed by the ILO with the approval of the governing but usually without the knowledge of the governed."

The Governing Body of the ILO is composed of sixteen government representatives, eight of management, and eight of labor. In accepting the constitution of the ILO, the national governments agreed "to the preparation of international rules for social insurance by a permanent body . . . of experts in social matters." The ILO office acts as an information center and publishing house. It is "staffed by experts drawn from many different countries, whose knowledge, experience, and advice are available to all the nations which are members of the Organisation. It has branch offices and correspondents in many countries."

Listed among the "experts" are Arthur J. Altmeyer, Chairman of the Social Security Board, Isidore S. Falk, Director of the SSB's Bureau of Research and Statistics, and Wilbur Cohen, its Assistant Director.

Throughout the article, the influence of the ILO on the daily lives of people in all countries is emphasized. The late President Roosevelt gave an indication of this in an address on November 7, 1941, in which he credited the ILO with "shortening the hours of labor, protecting women and children in agriculture and industry, making life more bearable for the merchant seamen, and keeping the factories and mines of the world more safe and fit places for human beings to work in."

Participating governments, according to *Medical Economics*, are bound by an agreement to submit annual reports to the ILO showing how the ILO proposals have been acted upon. "In some instances, ILO Draft Conventions have been presented to our Congress in their original form and wording. In other cases," it is stated, "they have been rewritten in a form deemed more likely to enlist support."

There is much more to prove that ILO has initiated, backed and promoted health legislation to which the medical profession has strenuously objected. "The ILO medical program would relegate physicians to the role of mere functionaries," *Medical Economics* observes. "Under wage-and-hour legislation, they would be classed simply as skilled workers. Private practice would be frowned upon. All medical services would be regulated by law. Administration would be a central government agency with the help of unified local agencies."

Medical Economics is to be commended for its thorough investigation of a very important matter.

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Kudos for the G.P.

It is generally recognized that the quality of medical care depends to a considerable extent on the adequate training and competency of the general practitioner. For the g.p. is in the front lines of medicine. He usually sees patients before the specialist does. In fact, he sees most of his patients through their illnesses without any assistance. When it is necessary he recommends the services of a specialist in whom he has confidence. This does not mean that he relinquishes his responsibility, for patients usually insist that he continue in collaboration with the specialist.

It is certainly no exaggeration to say that the g.p. has carried the lion's share of the burden on the home front during the war. Oftener than not he gives evidence of wear and tear due to the hard life he has led. The people of this country are deeply indebted to him for his untiring devotion to duty.

So a good word for the g.p. is always in order. It gives your Observer more than ordinary pleasure, therefore, to quote excerpts from an editorial appearing in the December 8, 1945 number of *Philadelphia Medicine*. Writing about the g.p., the Editor says:

> "This dependable person must have more than a smattering of each of the many medical specialties, if his patients are to receive efficient service. Each year new facts are learned, new therapies developed, often bringing galaxies of new problems all their own, and the good old g.p. must be on his toes to assimilate quickly some knowledge of these developments if only to answer the inevitable questions his patients are certain to fire at him. It seems but yesterday, for instance, when sulfonamide therapy blossomed overnight and one had to learn quickly the nice balance to be sustained in order to get the therapeutic effects without toxic symptoms, and also to recognize toxicity when it so often occurred. All of these new problems were just about mastered when penicillin and now several kindred remedies threaten to retire the sulfonamides to the limbo of things forgotten.
>
> "The awe-inspiring industrial development in the United States during the past four years has multiplied once more the problems the family doctor must face and conquer. This is so because industrial hazards and industrial diseases are touching individuals never affected by them in the past—and this trend will continue even without the stimulation of war. There are so many diseases the private physician never saw in the past but which are sure to be common in a highly industrialized land such as we have become. At random one thinks of the flash conjunctivitis which has had to be guarded against so zealously by welders, male and female; of the effects of butanol exposure in plants producing waterproof products; of silicosis and other dust hazards, and particularly the anthracosis of the coal miners; and of the radium poisoning which occurs among those working on luminous dials of watches."
>
> ". . . Specialism has become an important adjunct to medical practice but it cannot replace the efficient family doctor. In fact, it is the threat to his existence that makes socialized medicine an anathema to most Americans."

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Difficult Days

Not long ago your Observer was talking to a friend about the attitude of people generally since V-J Day. It was agreed that as a whole they were much more difficult than they had been during the war. As a matter of fact, there was more dissatisfaction, impatience, and downright perverseness than had been exhibited in the most trying times of the past few years. People were not taking peace in stride. They did not seem to know what they wanted unless it was less work and more pay. They were vociferous in demanding their rights. They were touchy and easily offended, felt imposed upon, and were often discourteous.

As this item is written, the greatest strikes in this country's history are in progress. In fact, paralysis of our economy is entirely possible. Disorder is not widespread, but the situation is tense. Overseas, our soldiers are staging demonstrations in protest against recent demobilization orders. They are homesick and have no stomach for occupying subjugated countries. Let our responsibilities abroad go hang! All of this is a humiliating spectacle to thoughtful citizens.

As he has often done in the past, Washington's C. K. Berryman graphically portrayed the current state of affairs in a cartoon which appeared in *The Evening Star* for January 12. He shows John Q. Public standing on a map of the United States in the midst of strikes bursting all around him. Overseas on the shores of Europe and the Far Pacific are figures of our G.I.'s calling, "I want to come home! I want to come home!" John Q. Public, pondering his sad plight, asks, "Why?"

By way of making this recital more personal, your Observer rises to remark that he, too, finds it hard going at times. Those around him are often plagued by the jitters, minor ailments, and indisposition. He can understand the jitters and the ailments, but indisposition "gets him down." He suspects rather strongly that a heavy dose of discipline would be a good thing. To which the strenuous protest would be, "You can't do that to me!" And in most instances your Observer would be content to let it rest there. For he craves peace, even at a sacrifice of his prerogatives.

Doctors can ill afford to indulge in such luxuries as these. Their patients expect them to be a calming influence in their lives. And, with few exceptions, they are that and much more.

It is time that our people behave like adults. Many of our present difficulties stem from selfishness, immaturity, and materialism. We sorely lack the spiritual qualities needed in times such as these.

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Psychiatry Unaccepted! There is no field in medicine in which there is greater interest at the present time than psychiatry. Few medical journals appear which do not contain an article on some phase of this subject. It is therefore surprising to find that doctors generally are somewhat skeptical of this branch of the healing arts. What proof is there of the accuracy of this statement? Innumerable conversations with physicians in which they have expressed themselves on this subject seem to your Observer ample justification for this assertion.

What is the reason for this state of affairs? To begin with, it is undoubtedly true that the older physicians know comparatively little about psychiatry. Their contacts with those in this field are infrequent. They are inclined to look upon psychiatrists as peculiar, which not a few of them are. They still rely on common sense and experience in dealing with emotional problems. Psychiatry is something not to be resorted to except in extreme cases.

Your Observer had occasion to talk this matter over with a nationally known psychiatrist a few weeks ago. With the views herein expressed the physician readily agreed. He said that psychiatry is more widely accepted by laymen than by physicians. How can it gain wholehearted acceptance by the rank-and-file of physicians? To him the answer was obvious: better psychiatric training in medical schools. Younger men even now are better trained than their elders, who form a resistance group with slight possibility that they will change.

Another obstacle to acceptance of psychiatry by the rank-and-file of the profession mentioned by this psychiatrist is the fact that the specialty is still in its infancy. That being true, diffi-

(*Continued on page 98*)

REPORT OF THE DELEGATE TO THE AMERICAN MEDICAL ASSOCIATION

Your delegate was present at all sessions of the House of Delegates of the American Medical Association held in Chicago, December 3 to 5. This was in many respects a momentous meeting, coming as it did so immediately after the introduction of S. 1606, a bill to provide a national health program, the "National Health Act of 1945."

The Nation's eyes were focused on Chicago. Those in attendance could sense the feeling that prevailed. The future of American Medicine seemed to many of us to depend upon some constructive action being taken at this meeting by the representatives of the medical profession. Surely no body of men and women should be more vitally concerned at this late hour. The threat of bureaucratic control with its many implications of disaster to national health standards was at hand.

A speech by Major General Paul R. Hawley, Acting Surgeon General of Veterans' Administration, was received with much acclaim. He showed his outstanding capability and above all an insight into the Nation's medical dilemma. Under his leadership the Congress recently adopted legislation relieving the Veterans' Administration of red tape in seeking the best physicians available. It can be predicted now that the ill veteran will be given the best that medical science can offer, untrammeled by bureaucratic zeal. An excerpt from his address follows:

> "How better can we establish this great organized profession in the esteem of the people of this country than for us together to attack this great public problem and show our people that a free and unregimented and ungoverned profession can solve the problem and that it is not necessary for the government to tell the medical profession how to run its business. I am just as interested as you are in keeping the government out of medical business. . . ."

Immediately following this address your delegate was recognized. Pursuant to your instructions two resolutions were read:

1. In re Survey of Medical Societies in Metropolitan Centers to find out to what degree information has been made available to the public concerning qualifications of physicians, recommending classification be made where this had not been done.

2. In re development of a specific national health program.

These resolutions were referred to the Committee on Legislation and Public Relations of which Dr. Edwin S. Hamilton of Illinois was Chairman. Your delegate appeared before this committee in support. Dr. Wm. Earl Clark, President, Dr. Herbert P. Ramsey and Theodore Wiprud were present by invitation. Their testimony was strongly effective in bringing a recommendation from the committee favorable to the resolution having to do with the development of a *specific national health program.* The Committee deemed the matter of preparing for the public lists of approved specialists a purely local problem for local solution. To this resolution it voted adversely.

Upon motion the House of Delegates adopted the Committee's report. Minor changes were made in the national health program resolution which have the effect of bringing, what probably will prove to be, more expeditious handling. Not only does the resolution instruct its Council on Medical Service and Public Relations to act, but also (as amended) the Board of Trustees. The referring of a *specific* program to the 1946 session of the House of Delegates for action is made mandatory.

California Resolutions

Two resolutions were introduced by the California delegation: one by Dr. S. J. McClendon recommending limitations of activities of full-time employees of AMA so that they "shall not engage in outside activities"; another by Dr. Dwight Wilbur which would cause the Council on Medical Service and Public Relations to be the sole agency for presentation of the attitude of the AMA relative to matters in which the organized profession should or must make representation to the public or government. The former resolution was referred to the Committee on Executive Session, the latter to the Committee on Legislation and Public Relations. Adverse committee reports were made. Thereupon followed a most active discussion.

It seems that California recently went through the throes of defeating a heavily backed socialistic state medical program. The resolutions followed what were conceived to be needs in adjustment of some of the difficulties that were encountered. A full airing of difficulties experienced by various constituent bodies of AMA is a good thing. Despite the loss in this instance on ballot, a tempered discussion gained for California many friends. It is believed the organized profession with its full-time employees will carry on with renewed confidence and less friction because of California pointing to what was honestly considered wrong.

ELECTION OF OFFICERS

Dr. H. H. Shoulders, for years Speaker of the House, resigned at the behest of friends, laying down the gavel to become candidate for President-elect. Dr. E. J. McCormack of Toledo, Ohio, Chairman of the Council on Medical Service and Public Relations, and Dr. Alphonse McMahon, formerly of St. Louis but now of Washington, were also candidates. Dr. Shoulders received the majority of votes cast. Upon motion he was unanimously elected.

From my contacts with Dr. Shoulders dating back some twenty years, at which time he was in attendance at Secretaries' Conferences as Secretary of the Tennessee State Medical Association, I know that the AMA will have the advantage of a chief executive well trained through years of administrative experience, who is fully cognizant from his years of contact with the practising physicians of their true needs. Dr. Roy Fouts of Omaha upon ballot became Speaker and Dr. Francis F. Borzell of Philadelphia, Vice Speaker. Dr. Olin West was reëlected Secretary and General Manager.

Drs. Isaac A. Abt, A. J. Carlson and G. R. Minot were candidates for the yearly AMA award for outstanding scientific effort during the year. The balloting was close; Dr. Minot, finally receiving a majority, was declared the winner of the award.

Your delegate took up the matter of additional representation of the District of Columbia in the House of Delegates with the AMA Secretary and General Manager, Dr. Olin West. A new apportionment will be made in 1946. Assurance was given that the District will automatically have two delegates if the membership meets the new quota. Your delegate would recommend that the Society's Secretary continue to keep in touch with this situation.

This report cannot close without paying tribute to the members of the Society's committees who have so unselfishly given of their time to develop plans for medical care and to the efficient guidance given by our Secretary, Mr. Wiprud. Through their example and persistence the national organization is now about to profit.

Respectfully submitted,
C. B. CONKLIN, M.D.
Delegate

CALENDAR OF MEETINGS

January 4	Committee on Cancer Control
January 7	Executive Board Committee on Service Physicians
January 9	Scientific Meeting of Society
January 10	Interprofessional Conference Section on Neurology and Psychiatry
January 11	Committee on Postgraduate Education
January 15	Committee on Cancer Control
January 16	Scientific Meeting of Society
January 22	Committee on Service Physicians Editorial Board of the Medical Annals
January 23	Scientific Meeting of Society
January 24	Board of Censors
January 29	Executive Board
January 30	Scientific Meeting of Society Committee on Medical Care

MEETINGS

Wednesday, March 6

BUSINESS MEETING

Nominations for office; report of Executive Board; presentation of Selective Service citations by MAJOR GENERAL LEWIS B. HERSHEY, U. S. A., The Director of Selective Service. Speaker and subject to be announced.

Wednesday, March 20

The Washington Gynecological Society will sponsor the program. Speakers and subjects to be announced.

Wednesday, March 27

The program will be presented by the *Section on Pathology and Laboratory Medicine*. Speakers and subjects to be announced.

FREDERICK MAY, M.D.

Dr. Frederick May is described by Dr. Samuel C. Busey in his "Personal Reminiscences" (1895) as "a pioneer who prepared the way for others, and the founder of the Medical Society of the District of Columbia." He was the third President of the Society and was reëlected for fifteen successive years. When in early January, 1847, he "declined a reëlection against the unanimous protest of his colleagues," it was due to rapidly failing health. "No other President," Dr. Busey observed, "has served in that office for so long a period."

Born in Boston, Massachusetts, on November 16, 1773, he received his Bachelor of Medicine degree at Harvard Medical School in 1795 and his Doctor of Medicine degree from the same institution in 1811. He arrived in Washington in 1795 where he spent the remainder of his professional life. He was on the staff of the Eastern Cholera Hospital, member of the National Institute, the Pathological Society of Washington, and the first Board of Health in the Nation's Capital.

In 1823 Dr. May established the Medical Department at Columbian College, now George Washington University, becoming its Professor of Obstetrics.

Dr. Busey describes Dr. May as "a scholarly man and an erudite physician," and "a ready and fluent lecturer." During the greater part of his long life he was said to have "commanded an enormous business."

Dr. May died on January 23, 1847.

Military Affairs

COMMODORE KNOWLTON AWARDED GOLD STAR IN LIEU OF SECOND LEGION OF MERIT

On September 26, 1945, Major General L. C. Shepherd, Jr., Commanding Officer, Sixth Division, on Guam, presented to Commodore Don S. Knowlton "in the name of the President of the United States . . . a Gold Star in lieu of a second Legion of Merit." The citation reads as follows:

"For exceptionally meritorious conduct in the performance of outstanding services as Division Surgeon of a Marine infantry division during the planning for and conduct of operations against the Japanese enemy on Okinawa Shima, Ryukyu Islands, during the period from 1 April to 21 June 1945. During the preparatory phase of the operation, Captain Knowlton, with untiring efforts, supervised the organization and training of the medical battalion within the division. With keen technical skill and professional ability he trained his command to a high state of readiness for amphibious operations. During the assault phase of the operation the medical companies under his direction kept constantly in contact with the advancing front line troops, offering prompt and efficient medical aid and surgical treatment to those wounded or injured in action. The ability of the individual corpsman, the capabilities of the unit medical officers, the efficiency of the medical organization, the promptness of the evacuation of wounded, all attested to his brilliant leadership. Throughout the entire operation he demonstrated an extremely high degree of professional knowledge both as a member of the medical profession and as a naval officer. He kept constantly in touch with the rapidly changing tactical situation so that he might better employ the men of his command. His sound judgment, both tactically and medically, his inspiring leadership and his intense devotion to duty were ever an inspiration to the men of the division and aided materially in the furtherance of the operation. His actions throughout were in keeping with the highest traditions of the United States Naval Service."

NEW PROMOTIONS IN RANK

Several promotions in rank of particular interest to the members of the Medical Society have recently come to the attention of the Editorial Board. Captain George W. Calver, who has held the appointment of attending physician to Congress for many years past, has been promoted to the rank of Rear Admiral. Captain Alphonse McMahon, who is Chief of the Training Branch of the Professional Division of the Bureau of Medicine and Surgery, U. S. Navy, has been commissioned Commodore. The same rank was conferred upon Dr. Don S. Knowlton, who is now on terminal leave, prior to his release from service.

The past few months have also brought word to the Society of recognition for services performed by many other members of the Society in the armed forces. Promotions not previously listed are as follows:

Abe Blajwas, from First Lieutenant to Captain
Ervin N. Chapman, from First Lieutenant to Captain
Ralph M. Crowley, from Lieutenant to Lieutenant Commander
Irvin Feldman, from Lieutenant Commander to Commander
Perry W. Gard, from Lieutenant Commander to Commander
James H. Gillen, from Lieutenant Commander to Commander
Henry A. Grennan, from Major to Lieutenant Colonel

Henry B. Gwynn, from Major to Lieutenant Colonel
Irvin Hantman, from Captain to Major
Stafford W. Hawken, from Lieutenant to Lieutenant Commander
Ralph J. Haws, from Lieutenant Colonel to Colonel
Herman S. Hoffman, from Commander to Captain
Gerald A. Hopkins, from Commander to Captain
John A. Long, from First Lieutenant to Captain
Lee McCarthy, from Commander to Captain
Russell McNitt, from Major to Lieutenant Colonel
Henry A. Monat, from Commander to Captain
Edward W. Nicklas, from Lieutenant Commander to Commander
Albert E. Pagan, from Commander to Captain
W. Warren Sager, from Lieutenant Commander to Commander
Isadore L. Sandler, from Commander to Captain
Daniel Sondheimer, from Captain to Major
S. Jack Sugar, from First Lieutenant to Captain
Harry S. Weitzman, from Captain to Major

BRIGADIER GENERAL BLISS NEW DEPUTY SURGEON GENERAL

Brigadier General Raymond W. Bliss, Assistant Surgeon General and Chief of Operations Service, has been appointed Deputy Surgeon General to succeed Major General George F. Lull, who requested his retirement after 33 years of service in the Medical Department, according to an announcement made by Major General Norman T. Kirk, The Surgeon General of the Army.

In addition to his new responsibilities, General Bliss will continue to handle the duties of Assistant Surgeon General and Chief of Operations Service. His outstanding contributions to the achievements of the Medical Department in these capacities won him the Distinguished Service Medal, the highest non-combatant award. Lt. General Albert C. Wedemeyer, Commanding General of the China Theater, made the presentation a few months ago in San Francisco just before they flew to China and other Pacific areas.

Born in Chelsea, Mass., May 17, 1888, General Bliss's Army career dates back to September of 1911, when he was commissioned a First Lieutenant in the Medical Reserve Corps. He served on active duty in the Reserve Corps until 1913, when he became a First Lieutenant in the Regular Army Medical Corps.

His tours of duty included assignments to medical installations in this country as well as the Philippines and Hawaii. In October, 1921, he was detailed to the Hospital Division of the Veterans' Administration in Washington, D. C., where he served for 18 months.

In November, 1936, General Bliss was transferred from Fort Sam Houston, Texas, where he was Chief of Surgical Service, to William Beaumont General Hospital at El Paso, Texas, in the same capacity. General Bliss went to London as Military Observer in September, 1940, and upon his return in January, 1941, was made Commanding Officer of the post hospital at Fort Sill, Oklahoma. In February, 1942, he became Surgeon, Eastern Defense Command and First Army, Governors Island, New York. In June of 1943 he was appointed Chief of Operations Service in The Surgeon General's Office and shortly after that he assumed the duties of Assistant Surgeon General.

He received his M.D. from Tufts College, Boston, in 1910. In 1920 he entered Harvard Medical School for a special course in surgery and remained in Boston for study in surgical clinics there and further work at Harvard. He received the honorary degree of Doctor of Science from Tufts College in 1943.

MEDICAL DEPARTMENT OF CARLISLE BARRACKS WILL MOVE TO TEXAS

The medical activities of Carlisle Barracks, Pennsylvania, and certain portions of the basic training program at the Army Service Forces Training Center, Fort Lewis, Washington, will be transferred to Fort Sam Houston, Texas, by March 15. The move involves approximately 6,000 enlisted men and officers.

Plans are being made for 5 battalions which will train about 5,000 men in basic and technician courses at Fort Sam Houston, and a basic Medical Department officers' course of approximately 1,100 newly commissioned officers will be in continuous operation.

There will be a School of Military Neuropsychiatry and a School of Roentgenology. Residency type training for Medical Corps officers will be carried on at Brooke General Hospital, which is located at Fort Sam Houston, and also at 9 other General Hospitals in this country, as part of the Surgeon General's plan to provide greater opportunities for professional advancement to the members of the Army Medical Corps.

The War Department calls for the continuation of Carlisle Barracks as an Army post and as the location for the Army Information School. Carlisle Barracks, which has been a center for Medical Department training for about a quarter of a century, is one of the oldest military stations in the country. It was established by the British during the French and Indian War, and has a rich background of colorful historical incidents.

AN OVERSEAS LETTER FROM COLONEL BIER

Editor's Note: This letter was sent by Lt. Colonel Robert A. Bier to his friends on the first of the year. Among them was the Secretary of the Medical Society. It was written from Frankfurt-am-Main, Germany.

Dear Folks:

When I last wrote you the latter part of 1943 I was just preparing to go overseas. After a few days at home the first week in January I reported to Camp Kilmer, N. J., for embarkation. Here we were outfitted and readied for our trip overseas. The camp was the most efficient and businesslike outfit I have ever seen in this man's army. It gave us all a feeling of security to have such a send-off. We went aboard the Ile de France with twelve thousand others. After a rather uneventful trip but with many memories and minor experiences we landed at Gourok(?), Scotland, a beautiful little gem of a harbor nestled at the foot of some typical Scottish Highlands. All the Civil Affairs officers went to Shrivenham (near Swindon), England. Here we took courses in German, Law, Civil and Military Government, Tactics, Map Reading, attended lectures on Supplies, Refugees and Displaced persons, and everything that would have any bearing on our work. We drilled, hiked, exercised until we got to be pretty tough soldiers, or at least for our mixed ages, etc. Most of the men went to U. S. units with a few to Missions to occupied countries, as Norway, Belgium, etc., against the time when these countries would be liberated. Some of us were sent to serve with the British Army. A sort of personalized lend-lease. The British would not or could not supply medical officers for their Civil Affairs (Military Government in occupied countries) so it was necessary for us to supply them. After a training period of about two months with the British I landed in Normandy July 3, and was attached to the headquarters 2nd British Army as Medical Advisor the S.C.A.O. (Senior Civ. Aff. Officer) and as such I was in charge of the medical and public health work of the B. L. A. (Br. Liberation Army). There were about a dozen U. S. medical and sanitary officers with me and we ran the show for the British. That in itself would make an interesting saga. As you now well know we went through northern France via Caen and Falaise where the famous gap occurred with its hundreds of dead German men and horses. It was a terrible sight, they say. I was too busy to go sightseeing then. Then across France to Amiens, Lille, where I spent several days with a young Frenchman, agent for the International Harvester Co., and his charming family of wife and three of the cutest little children I have seen in Europe. Into Belgium to Halle, near Brussels, near Louvaine, then on into Holland with a stop at Helmond. Here we quartered for a month during which time the Germans broke through and almost captured us. They were three miles away when they were stopped, incidentally with help from the 7th Armoured Div. U. S. November 10 we moved back into Belgium and went into winter quarters at Lindel, a small village near Neekpelt, just south of the Belgium-Holland border by the Escaut Canal. I was billeted in the parlor of the village butcher, where I had my office, reception room, living room et al. Leopold the butcher was a young intelligent ex-soldier (cook by the way) with a hard-working wife and three cute little girls, 7, 5 and 3 years. Maiette, the 5-year-old, was a dark-haired, dark-eyed little tease and she kept the house including me and my corporal clerk in an uproar most of the time. While in Holland I had made the acquaintance of some very nice families in Helmond and I returned there as often as I could to visit them as I felt more at home in Holland than any other place since I came overseas. The Dutch are grand people and so much like Americans.

The stay in Lindel was not too unpleasant though the weather was terrible, cold, damp, snow or rain, or heavy fogs, which froze on the trees, fences, houses and covered everything with a heavy coat of white hoar frost. The sun seldom shone. The hospitality of the Benares (the butcher) and the friendship of the three little girls helped to brighten an otherwise dreary existence. Leopold's skill as a cook was demonstrated on several occasions when he had some extra beef or pork steaks and invited me in to dinner with his famous pomme frits, the like of which I have never tasted before or since.

After several urgent calls from the U. S. Army to release me, Brigadier Lewis, my British boss, finally released me on February 1, 1945. I was sent to the 15th U. S. Army which then was on the secret list. Later it was released as a "secret weapon" and sent to Dinant. This is one of the prettiest and most picturesque towns I have seen in Europe. My stay at Dinant was not long as the 15th Army and I parted company under rather amusing and somewhat ridiculous circumstances. Anyone knowing the 15th will readily understand. Since the First U. S. Army was moving into interesting territory just then I was sent to it. I joined it at Euskirchen and then we moved up to the Rhine at Bad Goedesburg. Here we began to run into hordes of refugees and D.P.'s. At the Rhine we began to see our first typhus (not German typhoid) fever. Then to Marburg. Here I was sent back to Siegburg to the Siegburg Prison where it was reported that 800 inmates of 1,300 had typhus. It was true. The place was one dark, damp, smelly, squalid hospital of dead and dying. I was told to take two medical officers and a sanitary officer and set up to care for the poor unfortunates. We did. With 36 German nurses, 8 captured German medical officers and help from the inmates we organized a medical program that soon had the disease under control. We made an old garage into a 100-bed hospital and large prison cells into hospital wards. The backbone of the helpers was the Dutch doctors and others who helped us. Soon after getting Siegburg on its feet I was moved to Weimar. At Weimar I was sent to Eisenach to look after the medical and sanitary work of D.P.'s. At one time we had 31,000 in our one camp and a total of 60,000 in four camps, two of them 25 miles away. The story of the D.P.'s of Europe will make another story that should be very interesting especially to some of us who were here at the time.

After the D.P. episode at Eisenach, during which time I lived in the very quaint but modern hotel beside the famous castle of Wartburg, I returned to my regimental headquarters at Wiesbaden where I lived for a time in one of those famous Lebensbornheims. These are the very modern establishments for the delivery and subsequent care of Hitler's free-love babies. After we arrived on the scene in Germany that business fell off considerably. Though with fraternization it may have to be revived under different auspices.

The latter part of June I went to Darmstadt to take over as Public Health of Land Hessen. After organizing this I was sent to Regerungsbezerk Mainfranken to take over as Public Health Officer there with office at Wurzburg. Wurzburg before an American bombing raid in March '45 was one of Germany's most beautiful cities. Now it is in ruins. There are a few famous ruins left which give one an idea of its former grandeur. We were nicely billeted in one of the town's more pretentious mansions overlooking the river, a really beautiful spot. Our food was excellent, served by very pretty (and from some of the nicest families) frauleins. Hunting was my favorite pastime and in fact I spent all my spare (and at times not spare) time hunting deer, wild boars and other less important game such as rabbits (bigger than our jack rabbits), foxes and birds. My score to date is three deer (one of these I collaborated with Captain Jacob my assistant to kill) and three boar. Our public health section kept the mess in venison and boar meat more or less since August.

As good things cannot last forever I was rudely taken from my very comfortable and pleasant home and job in Wurzburg and ordered up to Frankfort to what the boys call "The Overall Picture." I now have that doubtful honor as it is known in the Army as being "among the brass."

Well folks, there you have it. Just another G.I.'s story of a country boy in a big war. No medals, no courts-martial (so far). I just "seen my duty and I dood it." Seriously, it has been a wonderful experience. It has made me a better American and I hope a better citizen of the world. There are many things in Europe that I like and wished we had in America but by and large we have the most wonderful country and people in the world and should strive to keep it that way. Winning the war was hard, but I believe keeping the peace will be harder.

MEMBERSHIP

The following applicants for membership were duly elected to membership at the business session, December 12, 1945.

Active Members

Lester S. Blumenthal, 1601 Argonne Place, N.W.
Frederic G. Burke, Children's Hospital
James T. Burns, 1835 Eye Street, N.W.
Andrew N. Conte, 6612 14th Street, N.W.
Joseph H. Cowan, 2922 Newark Street, N.W.
Francis S. DeCoste, 1835 Eye Street, N.W.
Vincent J. DiFrancesco, 3304 Pennsylvania Avenue, S.E.
James Spencer Dryden, 1835 Eye Street, N.W.
Paul Fleming Holland, 1801 Eye Street, N.W.
Eloise W. Kailin, 2817 Que Street, S.E.
Edward A. Krause, 3805 McKinley Street, N.W.
George Kriegman, Lieutenant, M.C., Army of the United States
K. Charles Latven, 1328 Eye Street, N.W.
Joseph S. Lawrence, 1835 Eye Street, N.W.
Thomas M. Leonard, 2501 33rd Street, S.E.
Abraham Al Levine, 4600 North Capitol Street
William Lewis, Jr., 1714 Rhode Island Avenue, N.W.
Anthony J. Nicolette, 1408 L Street, N.W.
Blanche W. Nimetz, 5501 16th Street, N.W.
Francis J. O'Bryan, 500 G Street, N.E.
Charles S. Robbins, 4900 Third Street, N.W.
M. Noel Stow, 1746 K Street, N.W.
Joseph H. Thibadeau, 3112 Alabama Avenue, S.E.

Associate Members

George David Adams, Lieutenant (j.g.), M.C., United States Naval Reserve
Dean Herbert Harding, Lieutenant (j.g.), M.C., United States Naval Reserve
William C. Manion, Lieutenant (j.g.), M.C., United States Naval Reserve

Charles Waters Thompson, Lieutenant, M.C., United States Naval Reserve
Charles Cecil West, Phar.D., 17th Street, N.E.
Karl Hayden Wood, D.D.S., 1835 Eye Street, N.W.
Jonathan Zoole, U. S. Public Health Service, 4th and D Streets, S.W.

The following applicants for Active membership were duly elected to membership at the meeting of the Executive Board, January 7, 1946, in accord with Amendment XI, Section 2:

Benjamin Parks Bell, Lieutenant, M.C., United States Naval Reserve
Paul Holley Gray, Lieutenant (j.g.), M.C., United States Naval Reserve
Charles R. Headlee, 329 East Capitol Street
Charles F. Hill, 2208 Tunlaw Road, N.W.
Raymond Allen Osbourn, Captain, M.C., Army of the United States
Nicholas G. Pistolas, First Lieutenant, M.C., Army of the United States

The following applicants for Active membership were duly elected to membership at the meeting of the Executive Board, January 29, 1946, in accord with Amendment XI, Section 2:

John Henry Bayly, 1726 Eye Street, N.W.
Basil Blumenthal, 3131 16th Street, N.W.
Cleo A. Brall, 1822 Biltmore Street, N.W.
Albert S. Bright, 1726 Eye Street, N.W.
Brooks G. Brown, 1835 Eye Street, N.W.
Arthur E. Cliff, 3901 South Dakota Avenue, N.E.
Frank Eugene Gibson, Jr., 1835 Eye Street, N.W.
Luther Allen Gilliom, Captain, M.C., Army of the United States
Malcolm C. McKaig, 1150 Connecticut Avenue, N.W.
Leon I. Nathanson, 1835 Eye Street, N.W.
Seymour J. Rosenberg, 1801 Eye Street, N.W.
Alvin R. Sweeney, Gallinger Municipal Hospital

The following applicants for membership will be voted on at the meeting of the Executive Board, February 25, 1946:

Active Members

Arnold Albert, George Washington University—1935
Emil Herbert Bauersfeld, George Washington University—1935
Charles Arbuthnot Campbell, Medico-Chirurgical College of Philadelphia—1912
Walter Henry Gerwig, Jr., University of Maryland—1935
Naomi Kaplan, New York University—1941
Ralph Bretney Miller, University of Pennsylvania—1930
Harold Stevens, University of Pennsylvania—1941
Leopold Erwin Wexberg, University of Vienna, Austria—1913; Louisiana State University—1936

Associate Members

Frank S. Bacon, University of Minnesota—1931
Samuel J. N. Sugar, 4218 28th Street, Mt. Rainer, Md.
Roland H. White, 8716 Georgia Avenue, Silver Spring, Md.

Recent changes in membership status:

Active to Associate

Reginald H. Mitchell
Earl R. Templeton

Associate reinstated to Active

Maurice van Kinsbergen

Reinstated to Active Membership

Paul A. Lichtman

Resigned
Active

Abraham R. Abarbanel
John Beverly Smith

Associate

Riley H. Guthrie

Nine New Life Members

Chapter II, Article IV, of the Constitution of the Society, reads as follows:

> Life members shall be active members who have been active members for a total of forty years. They shall have all of the privileges of active membership and shall be exempt from paying dues and assessments.

Our honor roll now numbers 76. The congratulations of the Society are extended to:

Seniority Number	*Date of Membership*
367 J. Ernest Mitchell	April 5, 1905
374 Lawrence M. Hynson	May 4, 1905
379 William H. Hough	October 4, 1905
382 James A. Flynn	October 9, 1905
383 James F. Douglas	October 14, 1905
384 Robert C. Ruedy	October 14, 1905
387 Edgar Snowden	October 20, 1905
388 J. J. Mundell	October 22, 1905
395 Herbert E. Martyn	November 2, 1905

who have for forty years been on the roster, meeting all dues and assessments and lending their support to the Society by frequent attendance. Their status is now elevated to Life Membership.

News and Personals

The American College of Surgeons announces the resumption in 1946 of its Sectional Meetings, which during the war were replaced by one-day War Sessions. Ten two-day meetings have been planned, nine to be held in various cities throughout the United States, and one in Canada. The sectional meeting which will include the District of Columbia will be held in Pittsburgh, March 11 and 12, at the Hotel William Penn.

Physicians, medical students, and hospital executives are invited to join with the Fellows of the College in these meetings. Among the subjects scheduled for discussion are: Treatment of Infection by Chemotherapy and the Antibiotics; Injuries to the Bile Ducts; Pre- and Postoperative Supportive Treatment; Treatment of Open Wounds; Treatment of Osteomyelitis; Management of Advanced Cancer; The Care of the Veteran; and The Reconversion Period in the Practice of Medicine.

The National Gastroenterological Association announces the establishment of an Annual Cash Prize Award of $100 and a Certificate of Merit for the best unpublished contribution on gastroenterology or allied subjects. Certificates will also be awarded those physicians whose contributions are deemed worthy.

Contestants residing in the United States must be members of the American Medical Association. The award will be made at the Annual Convention Banquet of the National Gastroenterological Association at the Hotel Pennsylvania, New York, June 20, 1946.

The Association reserves the right of first publishing the winning contribution of those receiving certificates of merit in its official publication, *The Review of Gastroenterology*. All entries should be limited to 5,000 words, typewritten in English, submitted in five copies, and addressed to the National Gastroenterological Association, 1819 Broadway, New York 23, N. Y., not later than May 1, 1946.

The American Urological Association offers an annual award "not to exceed $500" for an essay on the result of some specific clinical or laboratory research in urology. The amount of the prize is based on the merits of the work presented, and if the Committee on Scientific Research deems none of the offerings worthy, no award will be made. Competitors are limited to residents in urology in recognized hospitals and to urologists who have been in such specific practice for not more than 5 years. The selected essay will be presented at the meeting of the American Urological Association, to be held at the Netherland Plaza, Cincinnati, Ohio, July 22–25, 1946. Essays must be in the hands of the Secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tenn., on or before July 1, 1946.

The American Association of Obstetricians, Gynecologists and Abdominal Surgeons Foundation announces that the annual prize contest will be conducted again this year. For complete information write to Dr. James R. Bloss, Secretary, 418 Eleventh Street, Huntington 1, West Virginia.

The American Medical Association and the National Broadcasting Company have resumed their network broadcasts of the dramatized health program which has been on the air consecutively for ten years. The new series will be entitled "Doctors at Home." It will be a serial dramatic story dealing with a fictitious but typical American doctor returning from military service to care for his patients, reëstablish his community contacts and service his people in curative and preventive medicine.

The American Psychiatric Association and the National Committee for Mental Hygiene jointly announce the appointment of Captain Forrest M. Harrison, M.C., U.S.N., as Director of a newly established Psychiatric Personnel Placement Service. The service is designed especially to help physicians and psychiatrists make contacts with training oppor-

Photo by Leslie French, M.D.

PRESIDENT WILLIAM EARL CLARK assists DR. FRANK H. LAHEY with lapel microphone at scientific meeting of Society, January 16

tunities such as residencies, postgraduate courses and fellowships, and to aid institutions in locating suitable candidates for appointments. Physicians interested in psychiatry are invited to send in full biographical statements including personal data, education, training, experience and special desires, in order that this service may be of the greatest possible assistance to them.

Deans of medical schools, superintendents of hospitals, and directors of industrial organizations, clinics and others employing or participating in the training of psychiatric personnel, are invited to submit full information regarding available positions and courses, including financial details. Foundations, universities and other agencies are asked to report pertinent fellowships in psychiatry, psychosomatic medicine and child guidance.

Inquiries should be addressed to Captain Forrest M. Harrison, M.C., U.S.N., National Committee for Mental Hygiene, 1790 Broadway, New York 19, N. Y.

The Refresher Course which the faculty of **Georgetown University School of Medicine** planned to offer to returning medical officers of the armed forces, February 4 to April 27, has been cancelled. If sufficient interest develops, plans may be made for holding such a course at a later date.

Plans for the erection of a **Nurses National Memorial,** with a minimum goal of $2,000,000, were formally launched January 10 at a luncheon at the Mayflower Hotel. Major General Norman T. Kirk, Surgeon General of the Army, made the principal address. The memorial will take the form of a social center with club and home-like facilities for the comfort and convenience of the nurses, dietitians and physiotherapists in Washington.

Mrs. Norman T. Kirk is Chairman of the Board of Trustees and Mrs. Ross T. McIntire, co-sponsor with Mrs. Kirk. Others present at the luncheon were Mrs. Harry S. Truman, guest of honor; Mrs. Arthur H. Johnson, who presided; and several other speakers, including Mrs. Carl Spaatz; Colonel Wallace H. Graham, personal physician to President Truman; Dr. H. A. B. Dunning, Sr.; and Mr. Jarrett C. White, architectural adviser, who outlined the plans for the building.

A number of new committee appointments submitted by President William Earl Clark were approved by the **Executive Board** at its meeting, January 7. Membership of the Committee on Medical Care for Veterans will be as follows: Dr. John R. Cavanagh, *Chairman*; Dr. Maurice A. Selinger, *Vice Chairman*; Drs. Francis T. Coleman, Allen S. Cross, Charles E. Fierst, Elmer Klein, Harvey F. Kreuzberg, Henry A. Monat, George W. Reeves, John A. Swartwout, J. Lawn Thompson, Jr. and William J. Tobin.

To the Committee on Rehabilitation, of which Lt.

Colonel Henry B. Gwynn is Chairman, the following members were appointed: Drs. Darrell C. Crain, Custis Lee Hall, Raymond T. Holden, Winfred Overholser, and J. Lawn Thompson, Jr.

Additional appointments were made to the Committee on Service Physicians, as follows: Drs. Walter Atkinson, Brooks G. Brown, Stafford W. Hawken, Herman S. Hoffman, and John H. Lyons.

Dr. Walter R. Stokes was approved as Chairman of the Committee on Public Relations succeeding Dr. Valentine M. Hess, who was unable to serve the remainder of the year.

Dr. Russell J. Fields was nominated to succeed himself as representative to the District of Columbia Nursing Council for War Service, Inc.

The Section on Neurology and Psychiatry presented the following program, February 7, in the Society's library: "'Combat Fatigue' Following Surgery," Dr. Leslie Farber, Surgeon (R), U. S. Public Health Service, Marine Hospital, Norfolk, Va. The paper was discussed by Lt. Colonel Alexander Halperin, Flight Surgeon, Army Air Corps; Major Morris Kleinerman, M.C., A.U.S.; Comdr. Z. M. Lebensohn, M.C., U.S.N.R., and Dr. Donald Stubbs.

The George Washington University Medical Society devoted its scientific program, January 19, to a discussion of blast injuries. The subject was presented by Captain Rupert H. Draeger, M.C., U.S.N.; Captain Joseph S. Barr, M.C., U.S.N.R., and Comdr. Wm. Warren Sager, M.C., U.S.N.R. Discussion which followed was led by Professor Frederick Feiker, Dean of the School of Engineering, and Dr. Thomas B. Brown, Professor of Physics, both of the faculty of George Washington University, and two former members of the Army Medical Corps, Dr. Daniel L. Borden and Dr. Walter H. Gerwig, formerly Colonel and Lt. Colonel, respectively. Dr. Borden is Clinical Professor of Surgery at George Washington University School of Medicine.

The Washington Ophthalmological Society held a special meeting, February 4, in conjunction with the Ninth Annual George Washington University Postgraduate Course in Ophthalmology, in the Society's library. The following program was presented: "Tropical Ophthalmology," Dr. Harold G. Scheie, Philadelphia; "The Importance in Ophthalmology of Tropical Diseases to Health," Dr. W. P. Griffey, Senior Surgeon, U. S. Public Health Service; "Pathology of Selected Tropical Diseases," Colonel J. E. Ash, M.C., U.S.A., Director of the Army Medical Museum.

George Washington University and Georgetown University Schools of Medicine have pledged their coöperation to make Mount Alto Hospital "one of the leading veterans' hospitals in the country." Dr. Walter A. Bloedorn, of George Washington, and Rev. David V. McCauley, of Georgetown, have formed a "Deans' Committee" which will be "the sole judge of professional standards at Mount Alto." Professors and instructors associated with the two medical schools will be chosen on recommendation of the Deans' Committee as consultants and visiting staffs for Mount Alto.

The Committee will also pass on the qualifications of resident physicians who will become part of the hospital staff while they are doing postgraduate work to become specialists.

Similar arrangements between medical schools and veterans' hospitals already have been completed in Chicago, Minneapolis, New York, Boston and Richmond, according to an announcement from Veterans' Administration, and 46 of the country's 75 Class A medical schools have promised to coöperate.

The 48th Anniversay and "Fellowship Meeting" of the **Washington Medical and Surgical Society,** held at the Hotel Statler, January 28, was attended by more than 90 members and guests.

The essay for the evening was delivered by Dr. Leo B. Gaffney, Secretary of the Society, on the subject, "Surgical Treatment of Peptic Ulcer." A case report on intestinal obstruction in a three-year-old child was presented by Dr. Harold M. Hobart, assisted by Dr. H. H. Schoenfeld.

Fellows present to receive the greetings of the membership from Dr. Frank E. Gibson, permanent Treasurer of the Society, were Drs. Grant S. Barnhart, Earl G. Breeding, Arthur C. Christie, Coursen B. Conklin, Custis Lee Hall, Oscar B. Hunter, Ralph M. LeComte, Thomas C. Thompson and William G. Young. All of these members have been elevated to the status of Fellowship through more than ten years' membership in the Society, whose rolls are limited to 35.

Dr. George H. McLain, President of the Society, presided. Present as guests were Dr. William Earl Clark and Theodore Wiprud, President and Secretary, respectively, of the Medical Society of the District of Columbia.

Several Washington physicians attended the **Middle Atlantic States Regional Conference on Medical Service and Public Relations** which was held in Philadelphia, January 31, in the auditorium of the Philadelphia County Medical Society's building. Dr. Joseph S. Lawrence, Director of the Washington Office of the Council on Medical Service and Public Relations of the American Medical Association, discussed legislation, and Theodore Wiprud, Secretary of the Medical Society of the District of Columbia, described the public relations program which has been carried on in the District of Columbia and the future possibilities in this field.

Members of the Medical Society who were present in addition to those who appeared on the program were Dr. William Earl Clark, President, Dr. Walter R. Stokes, Chairman of the Committee on Public Relations, and Dr. Frank D. Costenbader, Chairman of the Committee on Medical Care.

A group of physicians and laymen met at Pierce Hall, January 26, "to set up a civic organization in Washington to carry on educational work for a national health program and to take any active legislative steps necessary to help implement that program, especially for compulsory health insurance." The group is further committed to support President Truman's national health program.

Dr. Anna Tulman-Rand, Chairman of the District Chapter of the Physicians' Forum, called the conference and was elected Chairman of the Steering Committee. Others who will serve on the Committee are Dr. Irving Winik, Dr. Dorothy Ferebee, Miss Margaret Stein, medical economist, Benjamin Asia of the District Chapter of the National Lawyers' Guild, and the Rev. Francis W. McPeek of the Washington Federation of Churches.

The Clinico-Pathological Society met at the home of Dr. Matthew White Perry, February 5. Dr. William J. Tobin read a paper on "Combined Orthopedic and Neuro-Surgical Injuries."

Dr. Charles Stanley White retired as Professor of Surgery at **George Washington University School of Medicine,** February 1, after having been a member of the faculty for 45 years. He has been succeeded by **Lt. Colonel Brien Blades,** Chief of the Thoracic Surgery Section of Walter Reed General Hospital, who is leaving the Army after serving in that capacity for the past three and one-half years. He has also served as consultant in thoracic surgery to the Surgeon General of the Army.

Colonel Blades received his degree in medicine from Washington University, St. Louis, in 1932. From 1936 to 1938 he was a Fellow in Thoracic Surgery at Washington University and Instructor in Clinical Surgery from 1938 to 1940. He is one of the Associate Editors of the *Journal of Thoracic Surgery.*

Dr. Joseph S. Wall, President of the American Academy of Pediatrics, was present at the 14th annual meeting of the Academy in Detroit, January 16–18. Dr. Wall read a report dealing with proposed child health legislation, particularly the Federal Maternal and Child Welfare Act of 1945. Also present at the sessions were **Dr. John H. McLeod** of Children's Hospital, who read a paper on histoplasmosis.

Dr. Jay I. Durand of Seattle, Washington, was installed as President of the Academy, succeeding Dr. Wall.

Dr. R. Lomax Wells was a guest speaker at the Fourth Annual Postgraduate Course in Industrial Medicine of the Long Island College of Medicine, which was held in Brooklyn, New York, January 15. His subject was "Health Evaluation of Applicants and Employees."

The American Typhus Commission Medal was awarded January 18 to **Dr. Leonard A. Scheele,** Senior Surgeon of the U. S. Public Health Service, for "exceptionally meritorius service" in the northwest section of the European theater of operations during 1944 and 1945. The presentation was made by Surgeon General Thomas Parran.

Dr. Scheele was Chief of the Preventive Medicine Section, Public Health Branch, with Allied Military Government forces in Northwest Europe. He is now Assistant Chief of the National Cancer Institute at Bethesda.

Among new appointments to the faculty of **George Washington University School of Medicine** are Dr. James Spencer Dryden, Clinical Instructor in Ophthalmology, and Dr. Roy Hertz, Clinical Instructor in Medicine.

Dr. J. Ross Veal, Associate Professor of Surgery at Georgetown University School of Medicine, was one of the speakers at the scientific session of the Mid-Atlantic Chiropodists Association, held at the Washington Hotel, January 12 and 13.

Dr. Walter A. Bloedorn was elected a Director of the Hamilton National Bank at the annual stockholders' meeting, January 8.

Dr. John A. Reed was elected a new member of the Board of Trustees of **Health Security Administration,** January 29. Reëlected to the Board of Trustees were Drs. Watson W. Eldridge, Oscar B. Hunter, Henry C. Macatee and Margaret M. Nicholson.

Colonel James E. Ash, Director of the Army Medical Museum, who has appeared on numerous programs of the Medical Society and other medical groups in Washington, has been awarded the Legion of Merit by Major General Norman T. Kirk, Surgeon General of the Army. The citation stated that Colonel Ash had "organized the most extensive tissue pathology service ever known to the world. The photographic and art service of the Museum was developed, which amassed a wealth of visual material—over 40,000 black and white photographs, over 4,000 kodachromes, and over 50,000 feet of colored movies."

The War Service and Postwar Planning Committee of the American Dental Association held an open forum for the discussion of problems relating to dental officers returning to civilian practice at the Stevens Hotel, Chicago, February 9. Dr. C. Willard Camalier, Chairman of the Committee, presided. Dr. Sterling V. Mead, President-elect of the American Dental Association, addressed the group. Both Dr. Camalier and Dr. Mead are Associate members of the Medical Society.

Dr. Robert W. Webb, of Dallas, Texas, has been appointed Chief Psychiatrist in the mental hygiene clinic to be installed in the Washington regional office of the Veterans' Administration. The clinic will open when the regional office moves to its new quarters at 1825 H Street, N.W., which may be this month. In addition to Dr. Webb, the clinic staff will include a psychiatrist, a psychologist, a supervising social worker and three social workers on a full-time basis, as well as 5 to 10 Washington psychiatrists who will work part time.

Dr. Webb, who served in the Army Medical Corps with the rank of Captain, pioneered in the treatment of psychoneurosis at Port Moresby, New Guinea.

Among the members of the Medical Society who appeared on the program of the **District of Columbia Dental Society,** January 8, were Drs. William Earl Clark, Maurice Protas and John A. Reed, who discussed the paper presented by Dr. E. Clarence Rice on "Dental Problems of the Diabetic Patient."

Dr. Alfred Golden is leaving Washington this month to take up his new duties as Director of Laboratories of the Baptist Memorial Hospital, Memphis, Tenn. He will also become Assistant Professor of Pathology at the University of Tennessee School of Medicine.

In a letter addressed to the Society's Secretary he expressed his appreciation for the privileges of Associate membership during his stay in Washington while on active duty at the Army Medical Museum in Washington. Dr. Golden held the commission of Major.

Dr. Walter R. Stokes appeared on the program of the 25th Anniversary Meeting of the Planned Parenthood Federation of America, which was held at the Waldorf-Astoria, New York, January 22 and 23. The subject of the conference was "The Challenge of Today's Children." Dr. Stokes presented a paper on "Welfare of the Child as a Goal of Marriage Counselling."

Dr. Leonard M. Dub addressed a meeting of the Washington Society for the Hard of Hearing, January 18. His paper was entitled "Understanding the Deaf Child."

Dr. Winfred Overholser addressed a public meeting, January 16, at McGill University, Montreal, on the subject, "Women and Modern Stress."

Stephen J. McDonough, Jr., Washington Science Editor of the Associated Press from 1933 to 1942, and well known to many members of the Medical Society, has accepted an appointment to the staff of *Modern Medicine*, which is published in Minneapolis.

Until his recent discharge as Major in the Medical Administrative Corps, Mr. McDonough served as Chief of the Planning Board, Technical Information Division, Office of the Surgeon General of the Army, and as a member of the Committee on Information of the Division of Medical Sciences of the National Research Council.

Dr. Herbert P. Ramsey, Chairman of the Washington Metropolitan Health Council, was the principal speaker at a meeting, January 21, of the community services and planning division of the Montgomery County Community Chest and Council. His subject was "Inter-Area Relationships in Health."

Doctors Hospital has organized a blood bank under the direction of Dr. Charles G. Stockard to serve its patients on a non-profit basis, the bank to be an affiliate of the Community Blood Plasma Bank at George Washington University. Immediate donations are needed to get the hospital bank in operation and persons with type "IV" and "O" blood are especially needed. Donors of any type blood, however, are urged to call Republic 4600 and ask for Central Laboratory for an appointment.

Children's Hospital and the Episcopal Eye, Ear and Throat Hospital will eventually share in the proceeds of an estate valued at approximately $180,000, under the terms of the will of Mrs. Anna H. H. Pitcher, who died in Washington, December 29, at the age of 75 years. She had resided at 1661 Crescent Place, N.W. The bequest is part of a trust fund which will be divided between three institutions upon the death of a sister-in-law who is to receive the income during her lifetime.

CORRESPONDENCE

WASHINGTON, D. C., January 11, 1946

DR. WILLIAM EARL CLARK
PRESIDENT, MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA
1718 M STREET, NORTHWEST
WASHINGTON, D. C.

DEAR DR. CLARK:

The medical profession deserves a full measure of glory in sharing honors with those groups and individuals upon whom credit can now be conferred for making such a brilliant success of the war finance program in the District of Columbia.

It was reassuring to us of the District War Finance Committee to know that we had the solid support and active coöperation of physicians and of hospital personnel. It was essential that we had this support.

In dollar volume the record credits in excess of $15,000,000 in war financing to our doctors and hospitals. But the record does not show the intangible, but none-the-less invaluable, influence of the profession in stimulating sales among patients and others that were credited to other groups. There is, of course, no way to measure the overall contribution of the profession to the war finance program. The very least we can say is that it was both substantial and essential.

To Dr. W. Calhoun Stirling for his untiring efforts as your Bond Chairman through five successive campaigns, goes our deepest gratitude. His coöperation has been a model of the type we thought at the outset that we could only hope to achieve. His was an unusually burdensome task. He had to devote time to the war effort when the demands of his profession gave him no respite. The shortage of doctors and hospital facilities that the war created and the extra responsibilities which the war imposed upon those professional men remaining to do the job appeared to inspire Dr. Stirling and his committee. They showed patience and fortitude at a time when men of lesser calibre and patriotism would have been dismayed at the task confronting them.

Our hospitals made a worthy contribution. Their quotas were substantial, but never once did they shirk the obligation that those quotas imposed. They, too, finished the job.

Every member of the District medical profession may well be proud of the glorious chapter they wrote in the history of war finance. It is a chronicle of brave men and women facing their duties squarely and discharging their responsibilities as only people can when fired with patriotic ardor and an uncompromising love for the things for which our country stands.

Sincerely yours,
W. J. Waller
Chairman, D. C. War Finance Committee

Washington, D. C., January 24, 1946

The Medical Society of the
District of Columbia
1718 M Street, N.W.
Washington, D. C.

Gentlemen:

The Bureau of Venereal Diseases, Health Department, Washington, D. C. is making available a refresher course for physicians interested in venereal diseases. We are planning to take only four physicians for a two-week interval, therefore, these refresher courses will be presented at intervals of two weeks. A maximum of four physicians can be taken at one time. The first class will start February 18, 1946. Applications will be received at the Office of the Director of the Bureau of Venereal Diseases, D. C. Health Department, 300 Indiana Avenue, N.W., Washington 1, D. C. Priority will be given to returned veterans and new classes can be scheduled every two weeks.

Our present plan is to have an informal discussion and bibliography presented at 11:30 a.m. on Monday, Wednesday and Friday, followed by clinic observation and practical demonstrations. The discussion and bibliography will include the following subjects:

1. Early Syphilis
2. Latent and Late Latent Syphilis
3. Neurosyphilis, especially Asymptomatic Neurosyphilis and Spinal Fluid Analysis
4. Serological Analysis
5. Gonorrhea, epidemiologic survey and public health problems involved
6. Chancroid, Granuloma Inguinale and Lymphopathia Venereum

Practical demonstration of selected cases will be held at 2 p.m. on Monday, Wednesday and Friday. These will include:

History, complete physical examination, taking of blood specimens, examination of darkfields, smears, cultures or other diagnosis tests as indicated. The discussion of diagnosis and differential diagnosis. Discussion of therapeutic procedure for each type of case. General public health and social problems involved.

Clinic hours which may be observed Monday, Tuesday, Wednesday, Thursday and Friday from 12–2 p.m., Monday, Wednesday and Friday 4:30–7:30 p.m. and Tuesday 6–7:30 p.m.

Visits to the Rapid Treatment Center and discussion of penicillin therapy of syphilis will be arranged.

Application for these courses should be made early and priority will be given first to returned veterans and next to physicians in the order of their application.

Very truly yours,
S. Ross Taggart, M.D.
Director, Bureau of Venereal Diseases

ALFRED VANDIVER PARSONS, M.D.

(1863–1945)

Dr. Alfred V. Parsons, formerly an Active Member of the Medical Society of the District of Columbia, died December 29, 1945, at Garfield Hospital after an illness of several months. He had practiced in the Takoma Park area for a period of 55 years. At the time of his death he resided at 732 Whittier Street, N.W.

Dr. Parsons was born in Baltimore, Md., March 19, 1863. He graduated from the University of Maryland in 1889 and began to practice medicine the following year.

He became a member of the Medical Association of the District of Columbia in 1893 and of the Medical Society in 1902, retaining his membership in the latter until 1932.

Dr. Parsons was keenly interested in sports as a hobby. He had been a member of the Washington Gun Club since 1924. He was known as an expert trap shooter and had won several prizes and trophies. He was also a member of the Capital Skeet Club, the Argyle Country Club and a charter member of the Manor Country Club.

Surviving are a daughter, Mrs. A. Stuart Young, Washington; a stepdaughter, Mrs. Howard Parsons, Washington; a stepson, William H. Dyre, Takoma Park, Md.; three brothers, William E. Parsons, Philadelphia, Eliphelet Parsons, Culver City, Calif., Dr. Luther Parsons, Baltimore and Fort Lauderdale, Fla.; and a sister, Mrs. C. W. E. Miller, Baltimore.

Vibratory Fremitus—Roberts

(*Continued from page 61*)

were comatose, irrational, or too weak or uncooperative to assist the examiner by following instructions for speaking syllables to give rise to vocal or tactile fremitus. Also in patients who could not be turned because of the presence of orthopedic or other appliances, or of surgical dressings, vibratory fremitus elicited by placing the tuning fork on the sternum with auscultation over both sides of the thorax frequently indicated the presence of pulmonary disease even when it was impossible to examine the patient's back by the usual procedures.

The physical mechanisms underlying this test are not clear. Undoubtedly some of the vibrations are transmitted through the bony structures, and these vibrations would not be affected by intrathoracic changes. Other vibrations are transmitted through the air-bearing structures; changes in the composition of these structures or the surrounding pleura probably account for the alterations in sounds of the tuning fork. It seems possible that in the future an even more valuable adjunct to physical diagnosis may be developed using the principles of radar as a modification of the test described here.

I believe that this method is of practical value and may be useful as part of routine physical examination of the chest.

Penicillin for Gonorrhea—Chinn, Olansky and Murphy

(*Continued from page 63*)

coexistence of syphilis should be kept in mind, and periodic serologic tests for syphilis should be made over a 90-day period.

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Ringworm of Scalp—Murphy

(*Continued from page 66*)

rebellious to treatment. Markedly inflammatory lesions and cases in which there is a vigorous reaction to the trichophyton test tend toward recovery. In all cases in which an early favorable prognosis is probable, treatment should be conservative. Cultural studies to determine whether the infecting species is of a resistant type and the trichophyton test to determine the degree of reaction are indicated before deciding upon the more drastic types of treatment.

X-rays when properly administered are successful aganist infections highly resistant to other forms of treatment, but this treatment has certain objections and dangers which should be carefully weighed. X-rays are not fungicidal, and the epilated infected hairs retain infective properties.

Ultraviolet irradiation is disappointing and is not likely to eradicate the infection.

Many of the drugs which are time-honored for treatment elsewhere make little progress in combating resistant types of infection. Many of these also give rise to chemical dermatitis with continued use.

Propionic acid with sodium propionate in proper strength is well tolerated and nontoxic. It can be obtained on the market under a proprietary name. Presistent daily treatment over a period of 2 or more months shows promising results with many cases. Fluorescence fades gradually but progressively under this treatment.

The U.S.P.H.S. has just issued a press release evaluating the results of various drugs used for topical treatment. This is most timely and should be most helpful as a guide to therapy.

Psychiatry Unaccepted—Observer

(*Continued from page 81*)

culties and lack of understanding are to be expected.

Yes, psychiatry still stands unaccepted by many physicians. But time and experience will prove a pretty good remedy for this situation.

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Our Classified List

Readers will recall that creation of the Classification Committee was mentioned previously in this column. The Society's Executive Board, which had long classified members according to type of practice, came to the conclusion that a better job could be done by a special committee. Since that time the new Classification Committee has begun to function. At its first meeting it decided on the course to be pursued. It agreed upon the following requirements and rules with respect to classification:

> "1. To be classified as a specialist, a physician must be recognized as such by Class A hospitals or by a group of specialists or special society approved by the Committee.
>
> "2. Each physician appearing on the list of specialists will be required to state his qualifications.
>
> "3. Physicians claiming a specialty must limit themselves to a single field; however, they may claim a subspecialty.
>
> "4. Qualifications of physicians claiming specialties will be investigated by members of the Committee in their respective fields.
>
> "5. The classification list will be submitted annually to the Executive Board for its approval."

In addition to the above, the Committee adopted a new form to be completed by members wishing to appear on the classified list.

The Committee is to be commended for the promptness and thoroughness with which it handled its assignment. Incidentally, every specialty and general practice is represented on the Committee so that careful and proper evaluation can be given the classification forms submitted.

MEDICAL ANNALS

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ADVANCES IN WAR MEDICINE AND SURGERY AS DEMONSTRATED IN THE EUROPEAN THEATER OF OPERATIONS*

MAJOR GENERAL PAUL R. HAWLEY,
M.C., U.S.A.
Acting Surgeon General, Veterans' Admtinisration

THERE are several differences between surgery in civil life and surgery in war; but the principal difference, I think, is that of the organization required. In civil life each individual patient ordinarily seeks his own surgeon, or is referred to him by his family physician, and makes his individual arrangements for his surgery. There rarely are more patients in urgent need of surgery at any one time than there are surgeons to provide. Patients are hospitalized, operated upon, and recover—all within the usual environment in which they spend their lives.

In war, however, the great majority of the injuries are incurred in places where it is impossible to do major surgery. Soldiers are hurt in such large numbers that the capacity of surgeons to care for them is taxed to the utmost; and the companions and friends of the injured are unable to leave their own tasks to arrange for their care. These conditions require careful organization, both of facilities to bring the patient to the surgeon, and of the surgeons, that none of the limited amount of surgical talent be wasted.

I shall not tire you with a detailed description of the organization which we set up to plan and operate the Medical Service of the European Theater. I find, since returning to the United States, that the organization in my own office was very much larger than in any of the other theaters. For this, I offer no apology. One of the anecdotes told about President Lincoln was that some person, when meeting the President for the first time, exclaimed: "What very long legs you have, Mr. President." Mr. Lincoln is said to have replied: "They are not at all too long; they are only long enough to reach to the ground." We had in my own office 130 officers and 275 enlisted men. There were times when this force worked long hours overtime to keep abreast of the work. This size of force permitted us to have a sufficient number of experts in every phase of medical operations to make careful plans and to supervise the execution of those plans.

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* Read before the Society, January 23, 1946.

The keystone of the organization of my office was the Professional Services Division. This division included an outstanding specialist in each special field of medicine and surgery. In this division professional policies were formulated, and education and training were planned and supervised. The other divisions of the office, largely administrative and operational in character, were guided by the Professional Services Division in every problem which involved the welfare of patients. The assignment of professional personnel was dictated by the Professional Services Division, each member of which knew all qualified men in his specialty that were in the European theater. The Supply Division consulted the Professional Services Division in the procurement and distribution of medical supplies. In short, the office was organized on the principle that the Medical Service was operated only for one reason, the care and treatment of patients.

This division was headed, first, by Colonel James C. Kimbrough, whom some of you undoubtedly knew when he was Chief of the Urology Service at the Walter Reed General Hospital. Following him was Brigadier General Elliott C. Cutler, the Moseley Professor of Surgery at Harvard. One of the outstanding members of this division was your own Colonel James N. Greear, who was the Senior Consultant in Ophthalmology.

The subordinate echelons of command, including both base sections and field armies, were organized similarly, but on a much smaller scale. These expert consultants in all echelons established the highest professional standards and saw to it that they were followed in every hospital.

The first task that confronted the medical service was the provision of hospitals for American sick and wounded. Military hospitals are classified either as "fixed" or "mobile." The equipment of fixed hospitals is more elaborate than the equipment of mobile hospitals and is not designed for movement, although it can be moved with great effort. Such hospitals may occupy regularly constructed hospital buildings, other buildings converted to hospital use, or temporarily constructed hospitals, or they may even operate under canvas. Mobile hospitals, on the other hand, are designed to accompany the moving armies and to provide the first hospitalization of the wounded.

Since the invasion of the Continent was based upon England, and it was realized that it would require many weeks or months to provide fixed hospitals in France after the landing, it was necessary to provide for a large number of fixed hospital beds in England before the Channel was crossed. Our fixed hospitals in England came from several sources. The British Army gave us 4 of their own hospitals which they could not well spare. The Emergency Medical Service, a civil medical organization created under the British Ministry of Health primarily to care for bombing casualties, had constructed 14 county hospitals for military use during the war and for civil use after war. They gave us 5 of these 14. These were of 600-bed capacity, which we considered too small, and we added to each of these 5 an additional 400 beds in steel Nissen huts. But all the hospitals which the British were able to give to us furnished only a very small proportion of the beds needed. We designed an American type of temporary hospital, to be built either with steel Nissen hutting, or of brick or of hollow tile, depending upon the availability of construction material in any particular part of the country. The design had to be simple for the reason that materials were scarce and expert labor even scarcer. The design was made in my own office after consultation with the British Ministry of Works who had to construct these hospitals. Of this type, we built 70,000 beds in England.

As our forces were gathered in England for the jump across the Channel, much temporary housing was required for them. I tried to have all of this temporary housing for American troops built in the form of hospitals in order that, when the troops left England for combat in France, hospitals would be immediately available. However, the additional material and labor required to build hospitals, as compared with temporary huts for housing, were such that I was able to have only 12,000 beds constructed under this plan. The rest of our construction was the conversion of British Militia Camps of semi-permanent construction into hospitals, and these furnished about 20,000 beds. Beds from all these sources totaled about 99,000. This would have been enough for the size of the American force as initially planned. However, the size of the American force in Britain kept constantly increasing until D-Day. There was no time for semi-permanent construction to keep pace with these increases, and, to meet the increased size of American forces, I had each hospital expanded by tentage pitched over concrete floors that were laid hurriedly. This gave us an additional 31,000 beds, and thus, in England alone, we had 130,000 fixed beds.

There were practically no existing hospitals in that part of Normandy in which the landing was to be made. Knowing this, my own office, in coöperation with the Office of the Chief Engineer of the Theater, developed plans for the hasty erection of fixed hospitals in France. This was one of the finest pieces of planning in the entire campaign. These hospitals were so designed that the initial construction was limited to concrete floors over which tents were pitched. Later, as soon as labor and materials could be made available, without interfering with the operation of the hospitals, huts were erected to replace the tents. We built about 11,000 beds of this type on the Normandy Peninsula in the vicinity of Cherbourg.

To staff the tented-hutted hospitals which we planned to build as rapidly as possible in Normandy, we had on D-Day 25 1000-bed general hospital units in staging areas in England, ready to move across the channel. These units were moved to France as rapidly as the new hospital plants became available. Units newly arriving from the United States after D-Day also were sent to France. As the armies moved forward following the breakthrough at St. Lo, the older and more experienced general hospital units on the Normandy Peninsula were relieved by new units from the United States, and the former moved forward to establish in Rennes, LeMans, Paris, Nancy, Verdun, Toul, Leige, Rheims, and Aachen. When the War ended, we were completing a new, large hospital center at Mourmelon, just south of Rheims. So much for our fixed hospitals.

After the breakthrough at St. Lo, the advance of our armies was so rapid that we were able to get existing hospitals and other usable buildings in the larger cities of France; and it was rarely necessary to construct more temporary fixed hospitals. At the height of the operations, which occurred during the Battle of the Bulge, we had 73,000 fixed beds in France and Belgium, in addition to the 130,000 in England, a total of 203,000 fixed beds. On the eighth day of February, 1944, there were 193,500 patients in these 203,000 fixed beds. This was in addition to some 50,000 or 60,000 patients in the mobile hospitals with the armies.

The medical service of armies must be highly mobile. This service starts in the front line. Attached to each platoon of fighting men is 1 Medical Department soldier known as the Company Aid man. He is well trained in first aid. His courage became proverbial in the European theater, and, in proportion to their numbers, more Company Aid men were decorated for gallantry than any other group in the Army. The Company Aid men exerted a great effect upon the fighting soldier. Combat commanders repeatedly told me that their men were not willing to undertake dangerous missions, such as night patrolling within the enemy lines, unless a Company Aid man accompanied them. We discovered early in the campaign that there was a much higher proportion of infection, and especially gas gangrene, among captured German wounded than among our own wounded. We were unable to explain this until one of our young medical officers, with a healthy curiosity, questioned several thousand consecutive wounded, both German and American, that came through his evacuation hospital. He found that the average length of time between receiving a wound and first aid attention to that wound was, for American soldiers, 12 minutes, and for the German soldier, 4 hours. We all believe that the low incidence of infection among our own wounded and the high recovery rate were due, in large part, to the fine work of these splendid medical soldiers in the front line. There were 2,500 of these Company Aid men killed in action and more than 10,000 wounded. The importance of the Company Aid men in the mind of the average combat soldier led to one rather amusing incident. Always when a man was hit, the cry would go up for the Company Aid man. One cowardly soldier, intending to escape further combat by wounding himself slightly, called first for the Company Aid man and then aimed his rifle at his left foot and pulled the trigger. The Company Aid man came so promptly that he saw the soldier shoot himself and was the most important witness at the court-martial that tried the coward.

After a wounded soldier received his first aid from the Company Aid man, if able to walk, he made his way a few hundred yards to the rear of the Battalion Aid Station. If he was not able to walk, he was carried to the Aid Station by litter squad, often with the help of a jeep equipped with litter racks. At the Aid Station he saw his first doctor, and there he could receive plasma and opiates and a better dressing of his wound. As soon as he was able to travel farther to the rear, he was sent to the Division Clearing Station by ambulance, sometimes stopping for further examination and treatment at an intermediate Collecting Station. The Clearing Station was located 4 to 10 miles in the rear of the front line with better protection against enemy fire; and here a more careful examination could be made and more extensive treatment given. Whole blood was available in the Clearing Station.

While sorting patients was done at each medical station in the chain of evacuation, serious sorting usually was first possible at the Clearing Station. Here there were more leisure and better facilities for careful examination than could be had farther forward. If the casualty was only slightly wounded and could return to duty within a few hours, he was held in the Clearing Station until he was ready for duty.

It was also at the Clearing Station that the first sorting of neuropsychiatric casualties was made. Here the Division psychiatrist spent the greater part of his time. He separated the cases of extreme physical exhaustion in which mild neurosis was developing from the serious anxiety neurosis. The former he held in the Clearing Station, fed them liberally with good food, and induced a long sleep with sedatives. After such good food and 12 to 18 hours of undisturbed rest, these mild cases were ready to return to the line.

If the case was one of a moderately wounded man who was in condition to stand further transportation by ambulance to an Evacuation Hospital 10 to 15 miles to the rear, he was moved to the Evacuation Hospital. But if he was very seriously wounded, as, for example, with a perforating wound of the abdomen, there was in the immediate neighborhood of the Clearing Station always a platoon of a Field Hospital, with 1 or more surgical teams attached, where the patient could receive expert definitive surgery without further delay and without being moved any farther. These Field Hospitals did a magnificent job. In World War I the case fatality of perforating wounds of the abdomen was 80 per cent. In World War II, in the European theater, only 20 per cent of these patients died. Often these hospitals were placed in advance of the Division Artillery; and I have seen the most expert surgery done in these tented hospitals while our own artillery was firing over them with deafening noise.

The Evacuation Hospitals received the large bulk of the wounded. These were of 2 types, 400-bed and 750-bed. They had their own organic staffs of surgeons and physicians, but frequently they had to be given additional help by surgical teams when they were receiving more wounded than they could care for with their own staffs. I have often seen in one long operating theater, constructed of 3 or 4 large tents pitched end to end, as many as 10 operating tables going at a time, and sometimes as many as 12. The Central Supply was usually placed in a T-extension of this long operating tent; and the quiet efficiency of this organization for surgery never ceased to impress me. With 10 operations going on at one time, most of them of a very major character, one rarely heard a voice raised, and never any dissension among the nurses and orderlies. It was a most inspiring sight.

It is impossible for organized hospital staffs to meet the wide variations of patient load that occur in combat. During periods of relative inactivity good surgical talent is wasted. When the battle is severe there are more patients than the organic surgical staff of a hospital can cope with. To provide the degree of flexibility to meet these extremes, to the medical organization of each Field Army was added, in this War, an Auxiliary Surgical Group. This group was composed of 61 surgical teams, each team including a surgeon, his assistant, an anesthetist, and a nurse, so that each team was self-sufficient and could be assigned to any hospital and work with very little assistance from the hospital staff. Most of these 61 teams were made up of general surgeons, but there were also neurosurgical teams, orthopedic teams, thoracic teams, maxillofacial teams and shock teams in each group. These teams were used primarily to provide surgical staffs for the Field Hospitals close behind the line; but they were also often used to reinforce the staffs of Evacuation Hospitals, and even General Hospitals, when the load became too great.

So much for the organization for surgery.

The greatest difference between the surgery of World War I and World War II lay in the better preparation of the patients for surgery during the War just ended. This also was the greatest single factor in the reduction of case fatality among the wounded. No plasma was used during World War I, and the use of whole blood was very limited. In World War II, in the European Theater of Operations, we used approximately 400,000 pints of whole blood in approximately 350,000 casualties. In our early planning, we estimated 1 pint of whole blood to each 3 pints of reconstituted plasma. We found, in the early days of the fighting, that more whole blood and less plasma were required; and soon we were using 1.1 pints of whole blood to each pint of reconstituted plasma. Plasma has the great advantage of ease of distribution near the front line. It is of great value as a temporary replacement of blood volume, but it is no substitute for whole blood.

One of the finest medical jobs done in the European theater was that of the operation of the blood bank and the distribution of whole blood to the front. Some time before the invasion of the Continent we were convinced that whole blood was absolutely necessary in the care of battle casualties. We encountered some curious opposition to the establishment of a blood bank, apparently on the theories, first, that plasma was all-sufficient and, second, that publicizing the use of whole blood interfered with the donation of blood in the United States to be processed into plasma. To meet the latter objection, very little publicity was given to the use of whole blood in the European theater until the war had almost ended. For this reason, the tremendously important part it played in the reduction of case fatality among the wounded is not as widely known as it should be.

When we had made our plans for the operation of the blood bank, we found that we were unable to obtain a single additional officer or man for the Medical Service of the European Theater. The need for more fighting men was so great that the services were unable to get any increases in their personnel. Consequently, we deactivated a 250-bed hospital and used the allocation of this personnel to staff the first blood bank. As our business in whole blood grew, we had to deactivate another 250-bed hospital to provide additional personnel. But this loss of 500 beds was compensated many times over by the product which this personnel produced.

Blood was collected from soldiers in the communications zone, both service troops and combat troops not yet committed to battle. There was never any shortage of volunteer donors. In other theaters of operation, donors were paid 10 dollars for a pint of blood. I am very proud to say that not one penny was ever paid in the European Theater of Operations for blood. Soldiers there were willing and anxious to donate their blood to save the life of a comrade. We did occasionally give each donor a generous drink of whiskey after he had given his blood. We had to be very careful, however, because we occasionally found a man slipping again into the queue after he had once been bled in order to get another drink.

Blood was processed and refrigerated in the central blood bank in England. It was distributed from there in large insulated containers of the thermos type. At the time of the invasion, each LST carried sufficient blood for the wounded which it would return to England and an additional 10 to 20 pints to be left on the beach for use of units already ashore. Before the beachhead was established, when the beaches were swept with enemy fire, the refrigerator truck full of blood went ashore. The crew of the truck persuaded an engineer soldier on a bulldozer to dig them a deep hole in which to back their truck to protect it from enemy fire, and that truck was the first of the branch blood banks on the Continent. As the beachheads were enlarged, distributing points were established on the Continent; and these were supplied with blood flown from the central bank in England. From these forward banks, blood was delivered to the front by these young officers and soldiers in jeeps. With the confused fighting of the early days, in an unknown country and in the black of night, these young people found their way to every forward hospital and clearing station, and there was never any shortage of whole blood. The work they did can be described as magnificent.

As the enemy was driven farther and farther back, the blood banks were pushed close behind our armies. The greater part of the supply of these forward banks was made by air. Only when weather prevented flying did we ship blood by rail or truck.

We increased our capacity for production of blood in Europe to 750 pints per day. As more and more troops were poured into the battle, it became evident that this amount would be entirely inadequate. Our own lines of communication had grown so long that there were too few troops in any one area to make collection of blood feasible. Since we were unable to produce more in Europe, even though we had increased the size of our blood bank, I sent an officer back to the United States to see whether or not we could not obtain whole blood there. This officer arranged for the collection and shipment by air of 1,000 pints daily. These shipments started in late October of 1944 and soon reached the maximum agreed upon. At first, the blood from the United States was shipped unrefrigerated, preserved with Alsever's solution. As you know, this resulted in the dilution of the blood by one half; and in 1,000 c.c. of this mixture, there was only 500 c.c. of whole blood. Opinions as to the relative value of blood diluted one half with Alsever's solution and refrigerated whole blood were about divided. Some surgeons appeared to prefer the diluted blood; others were convinced that the amount of fluid required to obtain an equal amount of oxygen-carrying elements was too great in the Alsever-preserved blood. In the milder case, where less than 1,500 c.c. of whole blood would be required, it perhaps made little difference whether blood diluted with Alsever's was used or whether whole blood was used. But I am convinced that the mildly diluted whole blood is much preferable to blood preserved with Alsever's solution in all cases where considerable amounts of blood must be used in a relatively short time.

In the later stages of the campaign refrigerated blood was flown from the United States. This was made possible by the development of a cheap and light container in which blood could be iced. The weight of the ice and of the blood was less than the weight of the blood preserved with Alsever's solution measured in terms of oxygen-carrying capacity. In other words, more oxygen-carrying capacity could be brought to Europe in the form of iced whole blood than could be brought in the form of un-iced blood preserved with Alsever's solution.

Undoubtedly the greatest single advance in the treatment of the battle casualty in World War II as compared to World War I was in the best resuscitation of the patient in shock. The vast majority of fatal battle casualties die either of shock or of hemorrhage or of a combination of both. The loss of blood is frequently considerable. Studies of blood volume made in our forward hospitals in Europe indicated that the more seriously injured average the loss of at least one third of their total blood volume. In many cases, and this is most important, the greatest loss of blood was internal and could not be detected by casual observation. One of our British colleagues states that an increase in the diameter of the male thigh of only 2 centimeters, which might be overlooked in a cursory glance, may mean that 1,500 c.c. of blood are outside of the capillary bed and actually beyond the vascular tree, extravasated within the tissues of the thigh. This is most important because, in severe injuries to lower extremities such as frequently occurred from land mines, as much as 3,000 c.c. of blood could be lost within the tissues of both legs without more than a few drops actually leaving the body.

The liberal use of whole blood saved thousands of lives, but it also took a toll of a very few lives. Our best information now is that about 4.8 per cent of transfusions were followed by some kind of a reaction. Of these, approximately 0.9 per cent were allergic reactions, 3.7 per cent were pyrogenic reactions, and 0.1 per cent hemolytic reactions. There was a very, very small number of cases in which we felt that blood produced fatal reactions. These reactions were due to either obscure subgroups in the "O" group of blood, or to the "Rh" factor. Curiously enough, initial transfusions rarely produced reaction. Later transfusions, particularly those given after a few days, sometimes showed the patient to have been sensitized by the earlier transfusions.

Another improvement in technic, which was involved in the lower case fatality, was in the field of anesthesia. More expert anesthetists were available from civil life than in the first World War, and we conducted extensive schools of training in anesthesia before the invasion. The newer anesthetics also helped. The anesthetic of selection varied with the type of case and the location of the hospital. Because a large percentage of the nontransportable casualties were wounds of the thorax, inhalation anesthesia was used most commonly in the Field Hospitals at the front. Our experience was that regional anesthesia is not the anesthesia of choice where wounds had to be generously débrided and much tissue excised. The amount of débridement required rarely can be estimated accurately until the surgeon has thoroughly explored the wound; and the extent of regional anesthesia required can, therefore, rarely be predicted before the operation. When used for this type of case, it tended to restrict the surgeon to the disadvantage of a patient. In other than thoracic cases intravenous pentothal anesthesia was widely used and proved safe and desirable.

After the patient has been resuscitated and prepared for operation, the most important step in his further treatment is the débridement of the wound. Débridement must be thorough and at the same time not wasteful. If properly done, serious infection afterward is rare. It may preserve a limb from amputation. It is difficult for an inexperienced military surgeon to visualize the path of the missile when he begins his débridement. The position of the soldier at the time he was wounded is of the greatest importance. For example, a wound over the heart does not necessarily mean that the soldier is wounded in the heart, since, if the soldier was lying down when hit, the missile may have traveled a great distance under the skin, doing little damage, and emerging near the hip joint. Similarly, if the arm is flexed when hit, but operated on in the extended position, the tract of the missile cannot properly be débrided. It is necessary that the arm be placed during the operation in the same position it was when the soldier was wounded.

Another thing that our surgeons learned with experience was that frequently there was little relation between the external appearance of a wound and the amount of damage done to soft-tissues within. It is not unusual to find great cavitation of soft tissues when a small missile passes through them at high velocity. Frequently muscle bundles are torn apart for surprising distances on each side of the path of the missile. These isolated muscle bundles are devitalized and must be removed during the débridement. Failure to remove all such devitalized tissue invites infection, particularly infection of the gas gangrene type.

During the last few months of the war, we were beginning to get most encouraging results in the temporary splicing of arteries with plastic tubes. For example, complete severance of the popliteal artery usually results in gangrene of the extremity. If, however, a plastic tube can be inserted into the proximal and distal cut ends of the artery and ligated in position, and the patient heparinized for a few days to prevent coagulation in the plastic tube, collateral circulation will expand rapidly. After a few days the plastic tube can be removed and the ends of the cut artery ligated. By this time there is sufficient collateral circulation to maintain the extremity. One should sound a note of warning, however, against the heparinization of patients when there is a possibility of internal concealed hemorrhage or when there are multiple wounds. The risk of secondary hemorrhage in such cases is very great.

Large numbers of peripheral nerves were sutured in the European Theater of Operations. Tantalum wire was ordinarily used, and nerve suture was delayed until the tract was free from infection. The optimum time, in our opinion, for the suturing of peripheral nerves is 3 to 6 weeks after injury. Some 6,000 cases of peripheral nerves sutured in the European theater are being followed carefully to evaluate the end results.

With the danger of infection mitigated by the use of sulfonamides and penicillin, we left all bony fragments in place unless they were detached from the periosteum. Every bit of viable tissue, including bone, should be preserved. As our experience accumulated, we frowned upon packing wounds open. Primary closure was not done, but small rubber tissue drains or a single piece of vaseline gauze gave much better results than extensive and tight packing.

In the surgical treatment of thoracic injuries, we prescribed the following principles: First, conservatism in the forward area; in the forward area only sucking wounds of the chest and pressure pneumothoraces should be dealt with. The majority of thoracic wounds do better if left alone for a time, except for the great necessity of keeping the pleural cavity emptied of blood and, with these exceptions, all of the definitive chest surgery was done in General

Hospitals in the rear areas. Decortication of the lung proved satisfactory up to the third and even to the sixth week after injury, and also even when there was a considerable amount of infection.

One experience that surprised us was how well head injuries do when definitive treatment is delayed. Patients with head injuries, treated with penicillin, often were transported many miles to the rear and waited 3 or 4 days before reaching a hospital where they could receive specialized surgery. Such patients did very much better than those operated upon at the front and later transported.

The experience in the European theater added nothing radical to abdominal surgery. Our principles were that all small bowel injuries should be closed when possible and where the blood supply remained adequate. Where the blood supply was damaged too greatly, portions of small bowel were excised. All large bowel injuries should be exteriorized by the simplest method available. This was done, of course, at the very front; and these colostomies were closed as soon as possible in the General Hospital in the rear.

The combined thoracic and abdominal wounds constituted the greatest surgical problem. First, it was frequently very difficult to be sure that wounds of the shoulder or back, or wounds in the region of the thigh and buttocks, did not enter both cavities. After the patient had been resuscitated, the surgeon had to determine whether both injuries could be attended to at one sitting. If not, obviously the abdominal procedure took precedence, and the chest wound was attended to at a second sitting. The excellence of the surgery at the front is shown by the fact that the case fatality rate in combined thoracic and abdominal wounds, many of them terribly severe, was less than 35 per cent.

In cases of maxillofacial damage it is particularly necessary that all possible skin and bone be saved. The only surgery that should be done in the forward areas is to see that an open airway exists, even if a tracheotomy has to be done. The first definitive treatment should be undertaken in the General Hospitals in the Communications Zone; but the later reconstructive work is done in the General Hospitals in the United States.

Until comparatively recently too little attention has been paid to wounds of the hand. For the average worker, the hand, next to the brain, is the most important part of his body. Without good use of his hand the worker cannot support himself and his family. Because of the liberal blood supply in the hand, and because of the urgent necessity for restoring function as soon as possible, we permitted primary closures of wounds of the hand at the front under favorable conditions. We also inaugurated intensive instruction of surgeons in the after-care of wounds of the hand, and the imperative necessity for preserving the maximum possible amount of function.

I have stated that, with certain exceptions, we did not permit primary closures of wounds. All amputations were of the guillotine type with skin traction applied at once. However, one of the great advances in military surgery in this war was the early secondary closure of wounds. The high quality of first aid administered early and the use of sulfonamides and penicillin either prevented or cured infection within a very short time; and secondary closures of wounds could be made as early as the third or fourth day. The optimum time is certainly before the tenth day when granulation tissue and cicatrization have already begun to defeat any attempt to draw together the lips of the wound without a secondary cutting operation. Such closures may be made by suture, by graft, or by a plastic operation. In our experience 75 per cent of all such secondary closures were solidly healed 2 weeks or less after the closure, and 90 per cent were healed after 3 weeks. Failures were few; and, even when the wound reopened, no damage was done to the patient. Secondary closures had their greatest influence in cases of compound fractures. The great majority of these wounds were closed in a few days and the fracture treated as a simple fracture. Osteomyelitis was a very rare complication.

As to the medical side of the picture, we were especially blessed by the absence of any serious epidemics. By far our most serious problem was that of hepatitis. Our first scourge of hepatitis arose in 1942 as a result of yellow fever inoculations. We had between 2,500 and 3,000 cases in this outbreak. Although only 2 of these resulted fatally, we were even forced to evacuate more than a thousand to the United States. Their convalescence, at best, was extremely slow, and there was a high admixture of neurosis among the prolonged cases.

The armies in Italy had had a very high incidence of infectious hepatitis during 1943 and early '44. We had had only a relatively few sporadic cases of this disease among the troops in England, and the incidence remained low after the invasion of the Continent until we were joined by the American forces which landed in South France from the Mediterranean theater. Hepatitis had been endemic in this force for more than a year. It appeared to spread to our own divisions which came in contact with the divisions from Italy within a short time after contact had been established. The Northern end of our long battle line, which had no contact with the troops from the South, had a very low incidence of infectious hepatitis. However, when an infected division was moved into a clean area, neighboring divisions soon began to show the disease. Without any conclusive epidemiologic work having been completed, we were all of the opinion that, among any other possible modes of transmission, the disease spread by direct contact.

There was practically no typhoid fever in distinction to the sharp outbreaks that occurred in the American Expeditionary Forces in France during the last war. Whether this was the result of a better vaccine or more rigid sanitation, I would hesitate to say.

Respiratory diseases caused no serious difficulties. In the course of frequent samplings of our troops the presence of influenza virus was demonstrated, but there were no serious outbreaks of influenza. The fall and winter of 1943 showed a sharp rise in virus pneumonia, but the disease never reached the proportion of an epidemic.

Venereal diseases were not a serious problem in England nor on the Continent so long as the fighting was severe. The rates rose rapidly and alarmingly after VE-Day. In the control of these diseases British authorities gave all the assistance possible under their rigid restrictions upon the invasion of the privacy of the individual citizen. British health authorities realized the handicap of such laws and customs, but British public opinion was not yet ready to accept the American principle of the subordination of individual rights to public good. The friendly occupation of Britain created a very grave public health problem in that country which may have its effects for many years to come. While gonorrhea was distributed throughout the British Isles on a small scale before the War, syphilis was almost entirely limited to larger seaports. The movement of troops of several regions from one place to another in the British Isles during the period of preparation for the invasion of the Continent spread syphilis inland, very much to the concern of the health authorities.

While the sulfonamides had already decreased the problem of gonorrhea very greatly, penicillin might be said to have completely solved the problem of cure. It is too early to know whether penicillin-fast strains of the gonococcus will develop, such as have developed with sulfonamides. We encountered no acute cases that could not be cured provided sufficiently large doses of penicillin were given. When penicillin was too scarce for use in the treatment of gonorrhea, our resistant cases were treated with hyperthermy. With the plentiful supply of penicillin, we no longer used the hypertherm.

While again the end result of the treatment of syphilis with penicillin cannot yet be evaluated, even if it is only 50 per cent effective, it marks a great advance over the treatment of syphilis under battle conditions. So tedious is the former method of treatment that it was practically impossible to give adequate treatment during active campaigns. With penicillin the soldier could be treated thoroughly near the front without undue loss of time.

I have frequently been asked for reasons for the greatly reduced case fatality in the European Theater of Operations in this War as compared with the last War. Several factors have contributed:

First, resuscitation. As this audience well knows, the better the surgical risk, the better the chances of survival of the patient. With the use of plasma and whole blood, patients could be brought out of shock before operation.

Second, better first aid by the Company Aid men on the battlefield. As our experience mounted we grew to have more and more respect for the work done on the battlefield itself by these trained soldiers.

Third, penicillin and the sulfonamides. These have greatly reduced infection. Furthermore, they permitted delay in operation of certain cases, notably penetrating wounds of the abdomen, until the patient could be prepared properly for operation with whole blood and other antishock measures. Until this time, penetrating wounds of the abdomen had to be operated on early if the patient were to have any chance of recovery. Six hours after incurrence was the usual deadline set. This meant that many patients had to be operated on while they were still in shock and when their blood volume was greatly reduced. Penicillin and the sulfonamides permitted us to delay operation in these cases as long as 36 hours with recovery of the patient.

Fourth, the standardization of treatment by the Professional Services Division of the Office of Chief Surgeon. These men were experts. They had expert surgical judgment. They knew the capacity of practically every surgeon in the theater. They prohibited experimental technics and insisted upon proved and sound surgical procedures. I cannot overemphasize the contribution by these outstanding men.

And, last, the better average training of the physician and the surgeon. Regardless of penicillin, sulfonamides, whole blood and other important factors, there is no substitute for a good surgeon. In my own opinion, the greatest difference between the medical service of World War I and World War II was in the better training of doctors. The medical schools of this country have done a magnificent job in the past twenty-five years, and doctors are very much better trained today than they were twenty-five years ago.

ANESTHESIA EXPERIENCES IN A MARINE EVACUATION HOSPITAL ON OKINAWA*

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CORPS Evacuation Hospital No. 3 was one of the three Marine Evacuation Hospitals formed at Camp Lejeune in August 1944. Its function was the final link in the chain of evacuation, accepting patients from the division hospitals both for evacuation and further treatment.

On April 6, 1945 the hospital started unloading on the various beaches of Okinawa. By April 14 the hospital was ready to accept patients. Wards and operating rooms were dug in and sandbagged due to our proximity to Yontain Airfield. Nightly air raids were frequent and bombs fell into the hospital area on one occasion, hitting two full surgical wards.

During the operation 14,210 casualties were evacuated, returned to duty, or died; 3,260 surgical cases were admitted and treated from these casualties. Of these, 1,084 operating-room procedures were carried out, 825 of which were considered major procedures. The majority of these were admitted during a 6 weeks' period between the middle of May and the last of June. During this period 3 operating rooms were kept busy night and day, the surgeons frequently operating during air raids.

With the exception of casualties in our own hospital vicinity as the result of bombings, sniping or operational accidents, all patients had been treated at one or more of the forward medical units, but after a long rough ambulance ride they were frequently in shock. All of these patients were first treated for shock, and with the exception of abdominal wounds and active bleeding surgery was not attempted until recovery from shock was complete. All responded rapidly to the use of either plasma or blood. The quantity of blood was never limited. It was shipped by air in refrigerated boxes from the States. If there was no sign of hemolysis or contamination this blood was kept refrigerated and ready to use for as long as 21 days, after which it was discarded. Type "O" blood was used routinely, and after 1 transfusion death, cross matchings were routine on all elective transfusions. This patient had a gangrenous appendix removed, and on the fifth postoperative day a transfusion of 500 c.c. of blood was started. After receiving 150 c.c. in about 20 minutes he became dyspneic and vomited. The blood was stopped, and the patient died within 15 minutes. Necropsy showed the recipient to be a type "B" and the donor a type "O" with hemolysis of the recipient's cells but no agglutination either on microscopic or macroscopic cross matchings.

THE CHOICE OF ANESTHETIC

The choice of anesthetic was not only influenced by the patient's condition and the nature of the surgical procedure but the equipment, personnel and time available. Two corpsmen for each operating room had been given some training in anesthesia during our staging period. Thus they could be depended upon to watch a spinal and give sodium pentothal in an uncomplicated case. Since we had neither a gas machine nor an intratracheal setup, the choice of anesthetic was limited to a local one and sodium pentothal. Many of the operative cases such as simple cleansing of a wound, redressings, and reduction of compound fractures with the application of a cast were carried out under preoperative medication without too much discomfort. There were 680 anesthetic procedures performed, 24 of which were therapeutic procedures (see tables 1 and 2).

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* The opinions and assertions expressed herein are the private ones of the writer and are not to be construed as official or reflecting the views of the Navy Department or the Naval Service at large.

TABLE 1

Summary of Anesthetics

TYPE	PER CENT	TOTAL CASES
1. Spinal	14.8	97
2. Nerve blocks	6.1	
Caudal-sacral		15
Cervical		1
Brachial plexus		3
Mandibular		10
Paravertebral		11
3. Infiltration and field blocks	51.6	339
4. Sodium pentothal*	29.0	167
5. Ether (drop)	1.2	8
6. Refrigeration	0.45	3
7. Morphine (intravenous)	0.45	3
Total	103.60	656

* 3.6 per cent supplemental to another anesthetic.

SODIUM PENTOTHAL ANESTHESIA

This was used routinely in a 2½ per cent solution. It was the sole anesthetic agent in 25.4 per cent of the cases and was used in combination with other agents in 3.6 per cent. It was used to supplement spinal anesthesia in 16.5 per cent of these anesthetics. Some of these were cases in which the operative procedure outlasted the spinal, others to relieve the discomfort of traction or nausea. The inductions of all ether anesthetics were routinely carried out with pentothal.

This anesthetic agent was not used in any head or neck cases. It was not used in any case when food was suspected of being in the stomach. This is a very definite hazard and one that constantly has to be guarded against. Many of these anesthetics were given by corpsmen without any complications. There was 1 intra-arterial injection of 2 c.c. of a 2½ per cent solution with no ill effects, and a few extravascular injections were treated by infiltrating the area with 0.5 per cent procaine solution. No irritation of the area was noted.

Pentothal sodium with continuous oxygen was used for 5 sucking wounds of the chest with the patient lying on his uninvolved side and with varying degrees of collapse and hematothorax. Foreign bodies were removed from the lung and pleural cavity, the wound débrided and closed, some positive pressure being used with a B. L. B. mask. In all of these cases and in fact any case in which there might be difficulty in maintaining an unobstructed respiratory passage, a pharyngeal airway was introduced. Due to the fact that the pharyngeal reflex is present until the lower part of the first plane, it is one of the last to be abolished under pentothal. Thus the induction must be deep before one attempts to introduce the airway, since gagging, coughing, vomiting or a laryngospasm may be produced. It should be introduced gently and withdrawn if the pharyngeal reflex is still present. A fixed eyeball, a relaxed jaw, quiet costoabdominal respirations, and finally no response to painful skin stimuli are good signs that the patient is ready for surgery.

TABLE 2

Summary of Anesthetic Therapies

PROCEDURE	TOTAL CASES
Sternal infusions	3
Sympathetic blocks	7
Inter-costal block	1
Refrigeration	8
Caudal-sacral injections	5
Total	24

For all minor procedures no preoperative medication was given. This was done in order that the reaction would be prompt and not necessitate having a corpsman sit with the patient until he reacted. In all major cases $\frac{1}{4}$ grain of morphine was given 45 minutes to an hour before surgery. The morphine frequently would not be ordered, and in these cases morphine given intravenously in the operating room worked very well. Due to the facts that the largest portion of the morphine came in syrettes and that this made an additional step of having to prepare a separate hypodermic of atropine sulfate, the routine use of atropine was discontinued. No signs of parasympathetic stimulation were noted; there were no cases of laryngospasm.

In surgery on the lower extremities, low spinal anesthetics were used at first almost routinely. Later it was noted that pentothal was far less shocking, especially for amputations in cases of gas gangrene. Blood plasma or fluids were given through the same needle used for the pentothal in any case in which supportive treatment was needed (see table 3).

Regional Anesthesia

Procaine hydrochloride was used in 72.6 per cent of the cases requiring anesthesia. The largest percentage (51.6 per cent) were given infiltration and field blocks for débridements and removal of foreign bodies. Spinal anesthesia was used in 14.8 per cent of the cases. No patients in shock or suspected perforated hollow viscus (except where ether was contraindicated) were given a spinal anesthetic. Spinal anesthesia paralyzes the sympathetics and produces peripheral vasodilatation and contraction of the bowel, thus lowering blood pressure and enhancing the chances of spillage in bowel perforations. The danger of squeezing more intestinal contents through the perforation due to contracture of the bowel is probably more theoretical than practical. Two cases of hollow viscus perforations were given spinal anesthetics with no apparent increase in spillage. Perhaps it may be argued that a quiet, contracted bowel reduces the size of the perforation, thus decreasing further leakage.

For spinal anesthesia procaine was used routinely dissolved in spinal fluid in doses ranging from 75 to 150 mg. The level of anesthesia was kept as low as the surgical procedure permitted. In cases of severely wounded or toxic patients as the result of infection, infusions of blood, plasma or glucose were started. In the uncomplicated cases the patients were watched by the corpsmen. They checked and recorded blood pressure, pulse, respirations, anesthesia level, and any complications. They gave oxygen for nausea, pentothal when the procedure outlasted the anesthesia, and a vasopressor drug if there was a fall in blood pressure. Ephedrine sulfate was given in all cases in which a spinal anesthetic was given, if there was no abnormal elevation of pressure. There were no complications other than nausea and occasional vomiting and a few falls of blood pressure in which the patients were given ephedrine intravenously in 25 mg. doses or neosynephrine intramuscularly in 3 to 5 mg. doses, oxygen, and, if necessary, fluids.

TABLE 3

Sodium Pentothal

PROCEDURE	TOTAL CASES
Débridement	44
Fracture, open reduction	49
Fraction, closed reduction	8
Dislocation, reduction	1
Foreign body, removal	13
Artery, ligation	2
Amputation	12
Abscess, incision and drainage	12
Gas gangrene, multiple incisions	3
Redressings	9
Secondary closure	4
Chest wound, removal of foreign body and closure	5
Cystotomy	4
Orchidectomy	1
Circumcision	1
Back, manipulation	1
Total	167

Nerve blocks constituted 6.1 per cent of all anesthetics given. There were no difficulties in this group. Nerve blocks were most useful in cases of head and neck injuries, cases in which there were full stomachs and cases in which the patient was operated on face down, such as anal operations and laminectomies. If necessary paravertebral block was used for laminectomies because of the lack of an intratracheal setup, or spinal anesthesia with a longer acting drug such as pontocaine instead. These anesthetics were very satisfactory (see table 4).

TABLE 4

Regional Anesthesia

PROCEDURE	TOTAL CASES
Spinal	
Perforated viscus, closure	2
Foreign body, removal	1
Testicle and cord, exploration	1
Artery, ligation	1
Abdomen, exploration and femoral vein, ligation	1
Débridement and cystotomy	1
Hemilaminectomy	1
Appendectomy	38
Amputation	9
Hernia, repair	4
Débridement	13
Fracture, open reduction	25
Total	97
Caudal—sacral	
Anal operation	13
Circumcision	1
Catheterization	1
Total	15
Other nerve blocks	
Fracture, mandible, wired	10
Fracture, humerus, reduction	2
Débridement, hand	1
Neck, exploration	1
Laminectomy	11
Total	25

ETHER ANESTHESIA

Ether was administered in 1.2 per cent of all the cases. Its use was limited first by the lack of a gas machine. Thus it had to be given by the drop method. The climate on Okinawa during the busy part of the operation was hot and humid. The operating rooms were plywood and would heat up. Then to aggravate the situation operations were frequently done at night during blackouts, and this necessitated complete closure of all openings. An open flame was used to heat the water sterilizer, which meant that ether could not be given while this was on.

The 8 patients who were given ether were all cases of suspected perforation. It was difficult to maintain surgical anesthesia because of the rapid evaporation of the ether even when wet towels were used. Whenever possible another anesthetic agent was selected (see table 5).

TABLE 5

Ether with Sodium Pentothal Induction

PROCEDURE	TOTAL CASES
Abdominal exploration	1
Lacerated diaphragm, closure	2
Perforated bowel, closure	2
Lacerated bowel, resected	1
Lacerated mesentery, repaired	1
Lacerated mesentery and perforated colon, repaired; débridement of fractured arm and leg	1
Total	8

REFRIGERATION ANESTHESIA

Two amputations of arms and 1 of a leg were done under refrigeration anesthesia. Two of these cases were admitted in shock. The injured extremity was refrigerated as part of the shock treatment. The third patient was refrigerated both to improve his condition and to observe his circulation. These patients were kept iced for an average of 24 hours. Three to 4 hours preoperatively a tourniquet was applied 3 to 4 inches above the operative site. Two of these cases complained of pain when the nerves were severed. The injection of a 2 per cent procaine solution into the nerve before cutting it will prevent this discomfort. The stump was refrigerated postoperatively for 48 hours, ice bags being used and then removed one at a time. The patients complained of very little pain, and there was very little drainage. Refrigeration alleviates shock and pain, inhibits infection, and lowers the metabolism of the injured part, allowing collaterals time to take over the circulatory burden.

TABLE 6

Therapeutic Procedures

PROCEDURE	CONDITION TREATED	NO. OF PROCEDURES
Sternal infusion	3rd degree burn	3
Sympathetic block (cervical)	Volkman's ischemic contracture	1
Sympathetic block (lumbar)	Vascular injury (peripheral)	6
Intercostal block	Fractured ribs	1
Refrigeration	Vascular injury (peripheral)	8
Caudal-sacral injection of penicillin	Caudal abscess (peridural)	5
Total		24

ANESTHETIC THERAPEUTIC PROCEDURES

The number of cases treated was limited, but these few were benefited. Sternal infusions were given to 3 patients with burns who did not have an accessible vein. It is an easy and efficient method of administering fluids, plasma or blood when venipuncture is difficult or impossible to perform. The Trukel sternal puncture needle makes the entry into the marrow cavity easy and eliminates the danger of entering the mediastinum.

Eight patients with peripheral vascular injuries were refrigerated. All but 1 of these were free from pain and infection, and time was thus allowed for the collateral circulation to become established and to take over the now lowered metabolic demands of the injured part. Thus, amputations could be performed with the patient a better surgical risk and perhaps at a lower level. Some of these patients were given repeated lumbar sympathetic blocks with the idea of increasing collateral circulation. These patients came to us too late for us to be able to evaluate the effectiveness of this therapy. One patient who developed a gas infection had a severed popliteal artery with a cold extremity up to a line 2 inches below the patella. After 24 hours' refrigeration and 2 lumbar sympathetic blocks the circulation was adequate to a level 6 inches below the patella, but the presence of gas was discovered and amputation was performed above the knee.

One patient with a peridural caudal abscess involving $S_{3,4 \text{ and } 5}$ on the left side was given penicillin through S_3 and S_4 foramen and into the caudal canal on 5 occasions. On the second and third injections purulent material was aspirated from the caudal canal after part of the penicillin had been injected. Cultures showed no growth, but the organism was probably a staphylococcus originating from a carbuncle on his forearm. This patient improved rapidly, and surgical drainage was not necessary (see table 6).

POSTOPERATIVE DEATHS

There were 12 postoperative deaths, but none was attributable to the anesthetic as proved by postmortem examinations (see table 7). There was 1 patient with an extensive third degree phosphorus burn who was given sodium pentothal for débridement and dressing. He received 6 units of plasma during the 2½ hour-period prior to the débridement and was in good condition. An hour after the procedure he developed acute pulmonary edema and died. The following is the pathologic report on this patient's lungs. "The sections of lungs show a homogeneous edema fluid filling many of the alveolar spaces. The smaller arterioles and bronchioles show edema of their collagen fibers and muscular coats. There is a laking of blood in the arterioles and capillaries and disintegration of the respiratory epithelium, with beginning separation from the bronchial walls. There is a great deal of blood pigment liberated by laked blood. Apparently following exposure to the flames there was spasm and injury of the vessels and bronchials, which subsequently underwent dilatation. Death occurred 6 hours later after the spasm subsided, permitting an extensive exudation into the air sacs found at autopsy." Thus, in cases of suspected inhalation of flames the use of pentothal should be contraindicated due to its vasodilating action.

TABLE 7

Postoperative Deaths

ANESTHETIC	PROCEDURE	TOTAL CASES
Ether	Lacerated mesentery and perforated colon repaired; débridement of fractured arm and leg	1
Ether	Perforated bowel, closed	2
Ether	Lacerated mesentery, repaired	1
Sodium pentothal	Abscess, incision and drainage	2
Sodium pentothal	Débridement	2
Spinal	Débridement	2
Spinal	Amputation	1
Spinal	Appendectomy	1
Total		12

SUMMARY

1. A report has been made of all anesthetic procedures in an evacuation hospital during combat. A total of 656 anesthetics were given, 98 per cent of which were either procaine or sodium pentothal. No special equipment was used, and satisfactory surgical anesthesia was obtained, without any complications.

2. Pentothal sodium was used in 29 per cent of the cases and found to be a valuable anesthetic agent. The importance of maintaining an unobstructed airway is stressed. Adequate respiratory exchange and the inconsistency of muscular relaxation limit the use of pentothal as the all-purpose anesthetic.

3. Procaine hydrochloride was used in 72.6 per cent of the cases. It is the safest anesthetic agent we have and its versatility is limited only by the technical ability of the anesthetist.

4. Refrigeration anesthesia is discussed and its use should advance the treatment of peripheral vascular injuries.

5. Anesthetic therapeutic procedures were carried out on a few cases with favorable results.

OCCUPATIONAL DERMATITIS IN AIRCRAFT WORKERS

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I WAS requested by a factory manufacturing airplane parts to investigate the numerous cases of dermatitis occurring among its workers, which was causing a considerable manpower loss to the company.

A personal visit to the plant revealed that most of the cases were among the workers of the paint shop, and a few in the assembly and welding department. The paint shop was unusually clean and well kept. During the spraying process, the workers wore respirator masks, but made no attempt to protect the exposed parts of the body. No gloves or any other type of protective clothing were worn. In the welding and assembly sections the workers frequently washed mechanical parts in Varsol and carbon tetrachloride, and, although protective gloves were provided, they were seldom used. Whenever aluminum and steel were riveted or bolted together, a seal of a zinc chromate paste was applied between the opposing surfaces. Twenty-five cases of dermatosis were tested with a variety of substances with which they commonly came in contact. Twelve additional persons free of any eruption were tested with these same substances as a control.

Description of the Dermatitis

The description of the dermatitis is of significance. In order of the frequency of appearance, the eruptions appeared on the backs of the hands; the flexor and extensor surfaces of the lower half of the forearms; the antecubital fossae; occasionally the face and the ankles at the sock level; and rarely the "V" of the neck. The lesions consisted of an erythematous papulovesicular eruption with the papular element in predominance. Many of the papules coalesced to form plaques which were secondarily excoriated and lichenified. In many areas scaling occurred with the formation of numerous denuded points which then oozed and became crusted. In one case the lesions consisted of erythematous, scaly, oval plaques on the trunk with the long axis of the lesions parallel to the lines of skin cleavage, resembling very closely pityriasis rosea. Two cases presented discrete, erythematous, crusted lesions on the forearms. These lesions were poorly demarcated, and the crusts were dark with blood pigment and heaped up to form rupioid lesions.

Substances Tested

Controls and individuals with the dermatitis were tested with the following substances:

1. Zinc chromate (primer)
2. Toluene substitute (thinner) with, contained by weight:
    - a. Petroleum naphtha 62%
    - b. Normal butyl alcohol 10%
    - c. Xylene 28%
3. Lacquer
4. Zinc chromate paste (LF18765 A)
5. Mimmax thinner
6. Varsol
7. Carbon tetrachloride
8. M-4 Hydraulic oil

Results of Tests

Patch tests of these 8 substances were applied to the backs of the patients and controls, in the standard manner, and allowed to remain for 48 hours, in all but 3 cases. In these 3, reactions were so severe that the patches had to be removed from 1 case in 4 hours, from the second in 12 hours, and from the third in 24 hours. In all 3 a large bulla appeared at the test site.

Results were recorded in tables 1 and 2 as follows:

1. Perceptible erythema........ 1 plus
2. Intense erythema........ 2 plus
3. Erythema plus papule........ 3 plus
4. Vesicules and/or bullae........ 4 plus

NOTE: It is interesting to note that no. 4 and no. 12 in the control list had a known sensitivity to chromic acid. Neither of these controls work in the presence of chromic acid. Both of them were females and gave histories of having had dermatosis of the ears as a result of wearing earrings. One of these had had the dermatosis investigated and had responded positively to patch tests with chromates on this previous occasion. Number 5 in table 1 is the patient who had an atypical pityriasis rosea type of eruption which was difficult to clear up.

A summary of the results of the patch tests in those affected with a dermatosis and in the controls is given in table 3.

TABLE 1

Individuals Having Some Form of Dermatosis

	ZINC CHROMATE (PRIMER)	TOLUENE SUBSTITUTE	LACQUER	ZINC CHROMATE PASTE	MIMMAX THINNER	VARSOL	CC14	HYDRAULIC OIL-m-4
1.	0	0	0	0	0	0	0	0
2.	++++	0	0	++++	0	0	0	+++
3.	++	0	0	++++	0	0	0	++
4.	++	0	0	++	0	0	+	+
5.	++++	0	++++	++++	0	0	++++	++++
6.	++++	0	0	++++	0	0	0	0
7.	0	0	0	++	0	0	0	++++
8.	+	0	0	++++	0	0	0	0
9.	++	0	0	++++	0	0	0	0
10.	+	0	0	++++	0	0	0	++++
11.	0	0	0	0	0	0	0	0
12.	0	0	0	+	0	0	0	0
13.	++++	0	0	++++	0	0	0	++++
14.	++++	0	0	++++	0	0	0	0
15.	0	0	0	0	0	++++	0	0
16.	0	0	0	0	0	0	++++	0
17.	++++	0	0	++++	0	0	0	0
18.	0	0	0	+	0	++++	0	+++
19.	++++	0	0	++++	0	0	0	++
20.	0	0	0		0	++++	0	+++
21.	+++	0	0	++++	0	0	0	0
22.	++++	0	0	++++	0	0	0	0
23.	++++	0	0	++++	0	0	0	0
24.	++	0	0	++	0	0	0	+++
25.	++++	0	0	++++	0	0	0	++

TABLE 2

Controls

	ZINC CHROMATE (PRIMER)	TOLUENE SUBSTITUE	LACQUER	ZINC CHROMATE PASTE	MIMMAX THINNER	VARSOL	CC14	HYDRAULIC OIL-m-4
1.	0	0	0	0	0	0	0	++
2.	0	0	0	+	0	0	0	++
3.	0	0	0	+	0	0	0	0
4.	+	+	++	+++	0	0	0	0
5.	0	0	0	0	0	0	0	0
6.	0	0	0	0	0	0	0	0
7.	0	0	0	0	0	0	0	0
8.	0	0	0	0	0	0	0	0
9.	0	0	0	0	0	0	0	0
10.	0	0	0	0	0	0	0	0
11.	0	0	0	0	0	0	0	0
12.	++	0	0	++	0	0	0	0

Since there are 2 control subjects which give a positive reaction to zinc chromate paste but none to the zinc chromate primer, it is believed that the other substances in this product were responsible for the positive tests in these 2.

TABLE 3

Summary of Results of Patch Tests

1. *Individuals Affected with a Dermatosis*

ZINC CHROMATE (PRIMER)	TOLUENE SUBSTITUTE	LACQUER	ZINC CHROMATE PASTE	MIMMAX THINNER	VARSOL	CC14	HYDRAULIC OIL
68%	4%	4%	80%	0%	9%	9%	48%
2. *Controls*							
16.66%	8.33%	8.33%	33.33%	0	0	0	16.66%

It is demonstrated that the probable responsibility in the causation of the contact dermatosis investigated falls with significance in the following order:

1. Zinc chromate paste
2. Zinc chromate primer
3. M-4 hydraulic oil
4. Varsol and carbon tetrachloride.

The zinc chromate primer is pure zinc chromate mixed with the toluene substitute thinner to make primer coat, and since the toluene substitute is an insignificant offender it is deductible that the zinc chromate itself is the primary offender.

The zinc chromate paste is a mixture of substances, and, although it is clear that the zinc chromate is, in itself, responsible for the production in part of the dermatosis, the other substances are probably involved in the production of some of the eruptions. The complete formula of this paste has not been made available at this time, and further investigation with its individual components must be postponed.

To the M-4 hydraulic oil petroleum base stock, polymeric materials, such as temperature coefficient improvers and oxidation inhibitors, have been added. What these additive materials are is not known at present, and investigation of these components must also be deferred.

These findings agree with those of other workers in the field. A. Fletcher Hall[1] at Santa Monica, California, investigated 755 cases of skin diseases at an aircraft factory and found that 65.3 per cent of all cases were due to the zinc chromate primer.

PROPHYLAXIS

In order to avoid the production of these dermatoses certain precautions should be taken.[2] Preventive measures should consist of:

1. Protection of the skin from contact with chemical compounds by partial or complete protective clothing devices.
2. Intelligent use of protective mixtures.
3. Use of suitable detergent materials, followed by bland creams to reduce irritation produced by the cleansing process.

Protection of the skin by the use of protective clothing devices:

Complete protection, by means of
  Suit
  Coveralls
Partial protection, by means of
  Caps
  Visors and goggles
  Gloves

Protective Mixtures:

Against Oils: Two preparations to be used. The first smeared thickly on the skin of the hands and forearms, and the second to be applied over the first by means of a small brush.

Preparation No. 1	
Titanium dioxide	25 parts
Kaolin	25 parts
White petrolatum	25 parts
Preparation No. 2	
Ethyl cellulose	5 parts
Mastic	8 parts
Castor oil	1 part
Acetone (technical)	86 parts

This covering should be removed by cloth or tissue towel and then thoroughly washed with detergent agents discussed before.

Against Zinc Chromate: Remove protective mixture with a towel, then wash with the following:

Aerosol O.T.	1 per cent
Sulfonated Oil	99 per cent

or

Tersus (Doak)

Follow with a bland cream or a hand lotion such as:

Stearic acid	10 parts
Cocoa butter	2 parts
Lanolin anhydrous	2 parts

Melt and emulsify with heated:—

Triethanolamine	2 parts
Water, sufficient quantity to make	100 parts.

General Measures: Workers coming in contact with these offending substances should change from street clothes to coveralls at the beginning of their work shift, and should remove these coveralls at the termination of their work shift, the coveralls to be left at the plant. These coveralls should be laundered frequently in order to avoid a concentration of the offending substances on the protective garments.

In addition to these coveralls, white cotton gloves which fit closely enough so as not to hamper work should be used as well as a cotton hood and goggles on those workers who spray the zinc chromate on the metal parts.

If at all possible, it was suggested that all applicants for a job in the departments in which these substances are used should have preliminary patch tests with the zinc chromate primer, zinc chromate paste, and M-4 hydraulic oil. In this manner, all individuals who have a preëxisting allergy to these substances could be eliminated. This method would, of course, not eliminate those persons who could develop allergies to these substances after working with them for a time, but it would aid considerably in decreasing the incidence of contact dermatitis.

TREATMENT

Treatment of the dermatosis was comparatively simple. It consisted of removal of the patient from his work and the use of bland applications in the form of an ointment or a liniment. In a few of the cases in which the eruption was severe and had been present for a long time X-ray therapy was necessary. The eruption in all but 1 case was completely cured in less than 3 weeks.

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PREVENTIVE MEDICINE IN INDUSTRY*

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IN THE older and narrower concept of industrial medicine preventive measures consisted primarily of those efforts directed at the protection of an employee from the effects of the materials with which he worked such as lead and gaseous fumes. This concept broadened into careful consideration of working conditions and included working space, improved lighting, ventilation and heating, pleasant surroundings, clean cafeterias supplying balanced and nutritious diets, shorter working hours, the correction of improper posture and apparel, and provisions for safety devices and first aid measures. Today, among progressive and intelligent employers the effort is to obtain and keep the employee group healthy. This, I believe, represents a forward-looking program of preventive medicine in the field of industry. Some industries, such as that of Kaiser, have branched out to include treatment. How far such programs will go I am not prepared to say. That is part of the broader picture of medicine of tomorrow. I simply want to talk to you briefly on how a well organized Industrial Medical Department can extend its usefulness as part of a Community Preventive Medicine Program.

Preventive Medicine in Industry starts with the preëmployment examination. The scope of this examination varies in different industries. The preëmployment examination of the Chesapeake and Potomac Telephone Companies with whom I am associated consists of a careful history, complete physical examination, routine urinalysis, and a blood Wassermann test. It is my hope that some day this will include a preëmployment roentgen examination of the chest. Where does a preplacement examination of this kind enter into the field of preventive medicine? Physical standards of acceptance for unlimited employment assure the prospective employee of his present condition and also assure the present employee group that its new fellow-worker does not come into that group with contagious or infectious diseases, and that the new worker has no handicaps that represent accident hazards to himself or to his fellow-workers. In some instances handicaps are such that the applicant for employment may be placed only on a specific job that he is quite capable of doing well and safely. The foregoing thoughts seem somewhat selfish and limited to employer and employee group interests. The applicant for employment, however, is benefited because he is informed of his impairments and is urged to place himself under medical or dental care for corrective measures. He may then return and receive employment after these corrective measures have been carried out. Had he not had a preëmployment examination he may not have sought medical advice or treatment in many instances. For example, the correction of vision with proper lenses, the care of carious teeth and gum infections, the correction of herniae, and the removal of diseased tonsils are important health measures that in the broader scope are preventive. When hypertension, heart disease and active tuberculosis are uncovered in applicants, these people are informed and directed to their family physicians for care. Many instances of positive blood serologic tests for syphilis are uncovered. Often the applicant is unaware of the condition. Provided he has no infectious disease, has no evidence of central nervous system or cardiovascular syphilis, and keeps under treatment, he is employable. The discovery of these cases and a program of intensive follow-up to see that the individuals keep under treatment are public health measures beyond dispute.

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* Read before the Society, November 14, 1945.

So much for the individual applying for a job. How about that individual after he has been employed? His health is watched through periodic health examinations and special occupational examinations, as in the case of cafeteria workers, motor vehicle operators and workers in lead, through examinations following sickness and accident disabilities, and in cases in which frequent incidental loss of time from work occurs and where the employee voluntarily requests examination. To the employee group there is offered from time to time mass chest surveys by roentgenogram, a recognized advance in tuberculosis case-finding. In our Company the plant men working in communities where the tick is prevalent are offered the prophylactic serum against Rocky Mountain spotted fever. It is accepted by the majority. A few years ago when there was some fear of an outbreak of smallpox, employee groups were offered vaccination. It was accepted by large numbers. These are voluntary programs so far as employees are concerned. They are offered as preventive measures, and no element of coercion enters into the program. A definite program of health education is carried out through conducted health lectures and periodic written information on matters of health. Much of this information is part of a preventive medicine program. Close supervision of all known cases of cured tuberculosis is carried out in order that we may be certain that the employee keeps well, follows his physician's instructions, and does not become a menace to his fellow-workers or to the community.

In addition to the above there are conducted health, nutrition, and home nursing courses which are planned to educate the employee group in those health matters that are part of a good, sensible, healthy way of living.

TABLE 1

Results of General Physical Examinations of Male Employees—West Virginia Company, Twelve Months Ending June 30, 1945

NUMBER OF EMPLOYEES	AGE GROUPS					
	20 to 30	30 to 40	40 to 50	50 to 60	Over 60	All ages
Examined	14	25	60	72	7	178
Showing normal findings	11	19	26	31	3	90
Per cent	79	76	43	43	43	51
Showing abnormal findings	3	6	34	41	4	88
Per cent	21	24	57	57	57	49
Requiring nonsurgical attention	1	4	10	22	3	40
Requiring surgical attention	0	1	5	4	0	10
Requiring dental care	1	2	14	15	0	32

In recent years the Telephone Company has developed a visiting nurse program that plays a very important part in employee education in health matters. These nurses make every effort to assist the employee's attending physician by seeing that his instructions are carried out. They can obtain first-hand information on the employee's living conditions and often make helpful and constructive suggestions that make for better conditions. Certainly improvement in home conditions constitutes a public health measure of fundamental importance. Our nurses are often able to guide employees into seeking medical care which they might not be inclined to do without some guidance and advice.

I want to point out that there is close coöperation between our medical department and the local health departments in enforcing mandatory restrictive measures and precautions necessary for the control of communicable and transmissible diseases.

In order to illustrate the value of periodic health examinations as part of an industrial hygiene program, I would like to give you our experience with 178 male employees of the Plant Department of the West Virginia Company examined because of specific occupations during the 12 months ending June 30, 1945. Tables 1 and 2 are self-explanatory.

From these tables it can be clearly seen that many correctible abnormalities have been uncovered. In cases of such conditions as heart disease and hypertension, we cannot, of course, offer correction, but we see that the employee is under medical care and provide him with restricted activity in his job that provides a minimum of danger and undue stress. No doubt exists in my mind that these are preventive measures in the broader concept of our understanding of the word.

TABLE 2

Abnormal Findings

	AGE GROUPS					
	20's	30's	40's	50's	60's	All ages
Carious teeth and gum infections	1	2	14	14		31
Defective vision (uncorrected)			1	8		9
Impaired hearing		1	3	3		7
Nose and throat abnormalities			2			2
Tuberculosis arrested				1		1
Heart disease			1	2	1	4
Abnormal blood pressure	1	1	5	10	1	18
Obesity		2	3	2		7
Varicocele			2			2
Hydrocele			1	1		2
Hernia			4	6		10
Hemorrhoids		1	2		1	4
Varicose veins				3		3
Syphilis		1	2	2		5
Enlarged liver			1			1
Amputations (end of phalanx)			1			1
Arthritis (chronic)				3		3
Glycosuria				1		1
Functional limitations and weakness (old fractures)	1	1	1			3

President's Page

THE ANSWER—VOLUNTARY PREPAID MEDICAL CARE

At a committee meeting the other night someone asked how an individual doctor could do something definite and constructive toward promoting good public relations. Mr. Wiprud, our Secretary, replied that in a way the behavior of each physician and what he had to say could be likened to a pebble dropped in a pool; the waves that went out from the point where the pebble dropped carried a surprising distance in all directions.

Reforms come as a result of popular education because no matter how good a program may be, it will not become a reality unless the people want it. At this time the standing of the individual doctor in the hearts and minds of the public is good. The standing of organized medicine is, in some respects, not so good, and there are a number of understandable reasons familiar to most of us.

Through what Dr. Frank Lahey speaks of as "free enterprise" and "quality competition," medicine in this country has risen to a very high level. There must, of course, be enough people in this country with incomes to preserve this system. However, for a decade or more it has become evident that quality medical care was not readily available to millions in lower income brackets. Costs of medical care, hospitalization, etc., often worked such a hardship on this group as to be tragic.

It was apparent to both leaders in medicine and to the public that some means must be devised to provide more people with the kind of medical service they should have. Older men in organized medicine could not seem to project their minds to evolve a suitable plan. The public and their representatives in Congress became increasingly impatient and annoyed by the delay of not months but years. In different states progressive groups with vision organized programs of voluntary prepaid medical care. They were faulty at first but they have been modified and improved until in many states there are plans that are most satisfactory to the public and doctors alike.

Before a national health program could be developed by the AMA's Council on Medical Service and Public Relations, the President's plan for compulsory prepaid medical care was announced. There is no question that it had a wide public appeal. To many people the dangers inherent in a politically controlled plan were of slight concern. Physicians, however, were perturbed and there was much heated debate. However, as Dr. Lahey says, there was "more heat than light."

Taking as objective a view of this situation as I can, I feel it is our duty to make the saner political leaders on Capitol Hill feel that we are keenly alive to the need for a plan that will work. Organized medicine is a going concern. It can take the successful prepaid medical plans that are functioning in various states and evolve a national program that will serve the people most adequately. As a matter of fact, it is not a matter of "can;" it is "must."

Let each one of us as we go about in our practices endeavor to enlighten our patients about a voluntary prepaid medical plan in contrast to one that is compulsory and Government-controlled.

Wm. Earl Clark

Editorials

CONTRIBUTIONS OF THE MEDICAL PROFESSION TO SELECTIVE SERVICE*

The service to the Nation of thousands of the members of the medical profession participating in the Selective Service System during World War II is most commendable. Even prior to the passage of the Selective Service Act the medical profession took measures to prepare for the part its members were to play. State medical societies appointed committees for national defense. These committees polled the members of the societies for volunteers to serve as Local Board Examining Physicians and members of the Medical Advisory Boards so that when the first examinations were made in November of 1940 the medical profession was organized and prepared to make complete physical examinations of registrants.

The Selective Service Regulations provided for one or more examining physicians to be appointed to each of the local boards, of which there are over 6,000. During the operation of the Act there have been appointed 27,714 Local Board Examining Physicians and 7,185 Local Board Examining Dentists. In addition there also were appointed 8,521 members of Medical Advisory Boards. Many of these doctors have served since the very beginning of the work. Others served until they themselves entered the armed forces when the country actually became engaged in war. Practically all of the doctors not in service volunteered their aid in this patriotic work.

Over 14,500,000 physical examinations were performed throughout the Nation by these uncompensated volunteer physicians in the operation of the Selective Service System's procurement of manpower.

Originally the Act was designed for the peacetime training of the youth of the country and it was anticipated that only one year's service would be required. It was also the belief that in so far as possible the registrants would be processed in their local communities by the men who knew them, serving as local board members and other persons in advisory capacities. A complete physical examination, therefore, was given locally to every registrant. This examination was based upon the physical standards then in use by the War Department. In some local boards these examinations were given at a convenient location to groups of registrants by one or more physicians, and in other instances the registrants were examined individually in the doctors' offices. Whenever the Local Board Examining Physician discovered a condition requiring consultation or the advice of specialists, the registrant was referred to the Medical Advisory Board. Following the advent of war, and the desire to expedite examinations, using the greatly enlarged facilities of the induction stations, the complete physical examination at the local board was eliminated. This by no means relieved the Local Board Examining Physicians of all of their work since it was still necessary in many cases to conduct a partial examination in order to detect obviously disqualifying defects, eliminating the sending of obviously unfit persons to induction stations.

The actual examination of the registrants was not the only work performed by the physicians, since they were frequently called upon by the local board members for advice and recommendations in reviewing the records of men previously rejected and also for advice concerning the seriousness of illnesses of dependents which were set forth as reasons for deferment of a registrant.

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* This is the second in a series of guest editorials by distinguished physicians and laymen. Others to follow will deal with the scientific, social and economic aspects of medicine.

During the war many changes in physical standards took place—a natural result of changing circumstances in the fortunes of war and manpower availability. The exigencies of war called for shifting of manpower from one branch of the armed forces to another; likewise the fluctuating needs of the armed forces brought changes in the physical requirements. The care with which the participating members of the medical profession assisted in the selection of men was proven to be of great value later, in the facility with which men could be shifted from one activity to that of an entirely different branch.

The Nation is today expressing its gratitude to these doctors who served in the Selective Service System by the presentation of certificates and the Selective Service Medal provided by Congress. Their work has been excellent, a tremendous contribution to the Nation's war effort.

MAJOR GENERAL LEWIS B. HERSHEY, U.S.A.
Director, Selective Service System

ANESTHESIOLOGY TODAY

No surgical specialty has made more progress in recent years than that of anesthesiology. Under the relatively new heading, "anesthesiology," this modern hospital service is responsible for the actual administration of anesthetics in the operating and delivery rooms. In addition, however, it embraces a large part of preoperative and postoperative care, the selection of the anesthetic agent and the method of its administration; and, for all services in the hospital, gas therapy and resuscitation, and diagnostic and therapeutic nerve blocks. Furthermore, it often includes intravenous supportive care with plasma and blood. Finally, following the lead of the Army, civilian hospitals are beginning to designate the anesthesiologist executive officer of the operating rooms.

Recognition of the advantages offered by full utilization of the specialty is outstripping the availability of trained men in the field. Even the laity are learning that he who gives an anesthetic is much more important as a safety factor than what he gives. This is dependent upon the fact that errors in selection of the anesthetic agent are much more rarely the causes of serious complications than failures in resuscitative technic or mistakes in management of the anesthetic period.

This change in emphasis from specialty tools to the personnel who use them is a natural development which surgery itself passed many years ago. No one now asks the brand of scalpel or clamp to be used by the surgeon.

Anesthesiology is now attracting first-class men in greater numbers than was possible when the anesthetic was administered by technicians under the complete control and responsibility of the surgeon. This fact with the growth of teaching services is enlarging the teamwork between surgeon and anesthetist. Such coöperation has been the biggest factor in making possible the surgical treatment of conditions not approached only a few years ago. Marked recent successes in intrathoracic and vascular surgery are examples in this category.

Today there is a multiplicity of anesthetic drugs available and some of the newer ones have excited public as well as professional enthusiasm. Nevertheless, the emphasis on fundamental anesthetic principles is greater than ever before. One evidence of the spread of this educational policy is the tendency to require residents in training for surgery to study anesthesia from three to six months. This step alone, when it is taken on a widespread basis, will act to the great advantage of the entire profession.

The tie-up with the preclinical or basic sciences is as prominent in anesthesiology as in any medical specialty. Accordingly, the anesthesiologist is in a favored position to help lessen the frequently wide gap between clinical research and advantage to patients. The overwhelming importance of the rôle of oxygen and the dangers in the use of carbon dioxide and the analeptic drugs in resuscitation are good examples.

All in all, anesthesiology today offers an excellent opportunity as well as a challenge to the competent medical graduate searching for a scientific and a clinical outlet for his talents.

D. S.

NEEDED—ONE MILLION DOLLARS FOR A NEW UNIT FOR CHILDREN'S HOSPITAL

Plans have been developed to initiate a campaign on April first to secure funds of at least one million dollars to construct a new building on the W street side of the square now occupied by the Children's Hospital which would replace the ancient and out-moded structure now occupying this site.

Over twenty years ago, the District building inspectors condemned this main building of the Hospital as unsafe for housing sick children but because of lack of space and inadequate housing facilities for hospital personnel, this ancient and inadequate structure has been used for the accommodation of nurses and resident physicians.

The old building intended to be replaced by a modern structure was built in 1875 to 1878, long before fire proofing was customary or compulsory. For a score of years or more it has not been utilized for the care of sick children but only to house healthy personnel of nurses and doctors, who are subjected not only to the hazards of fire but also to those of storm and rain, which not infrequently pours down through a leaking roof that can only with difficulty be kept in condition.

The basement floor of the old building is now occupied by the Dietary Department and supply rooms and a large part of the first floor by administrative offices. To repair this unit of the Hospital today would cost almost as much as to build it anew. To fire-proof it is impossible. These are the reasons why the Board decided that its replacement can be put off no longer.

Preliminary estimates of the cost of constructing in its place a modern hospital unit which would meet all the present emergency needs set the minimum cost at a million dollars. The plans include additional wards to care for the unusual numbers of children now crowded into hallways and sun porches as overflows from the wards in the newer, more modern wings. They provide for a more scientific diet kitchen, a better formula laboratory, and the greatly desired laboratory for the new Research Foundation. In addition they will have efficiently arranged, up-to-date administrative offices, and a specially designed unit for the care of polio patients. The enlarged facilities which this new building will afford will permit expansion of the Hospital's program for training young doctors and nurses in the care of sick children.

The facilities of the Children's Hospital during the past few years have been inadequate to meet the demands for the proper care of sick children because of the large and rapid increase in the population of the city itself, now numbering just short of one million, and the enormous expansion of the contiguous suburban areas that find in the Hospital a haven for the acutely ill children requiring diagnosis and treatment.

Upon the occasion of the outbreak of communicable disease such as we have experienced during the past two years because of the prevalence of poliomyelitis, the burden of caring for the increased load necessitated by epidemics has been tremendously increased. The Hospital received 90 per cent of all children under the age of twelve suffering from infantile paralysis; only by enclosing porches and utilizing space for beds which should properly have been devoted to other needs was the Hospital able to successfully carry on during the past two summers. It is contemplated that the new building will contain facilities for the care of poliomyelitis cases which would occupy one or perhaps two floors of the new wing. The necessity for adequate provision for these cases has been amply demonstrated by the experience of the last two years.

The functions of the Children's Hospital as set forth in the first Article of its Constitution, adopted in 1870, consist of:

1. The care of sick children
2. Instruction in the diseases of children
3. Instruction of young women in the duties of nursing.

The two functions last named continue to occupy the interest of the Hospital and its educational activities have now reached a high level.

Close affiliation is maintained with the George Washington and Georgetown University Schools of Medicine whose students receive first-hand instruction in the wards and outpatient departments of the Hospital under skillful control provided by a full-time director of pediatric instruction and by the members of the entire Medical Staff.

The Board of Directors has approved the request of the Medical Staff that a Research Foundation be established by the Staff for the advancement of knowledge of the diseases of children. It has long been felt that the results of the study of the sick children within our wards should accrue to the benefit of all who might be reached through the medium of publication of our work. Through the skill and energy of many members of our visiting and resident staff, valuable contributions have already been made to the store of knowledge of pediatrics. We believe, with the formation of the Research Foundation, that support in a financial way may be secured to further this important field of endeavor.

It is felt that an appeal to the citizens of Washington for help in securing the necessary funds to complete this much needed addition to the Hospital plant will meet with their wholehearted support. When it is realized that each day over 200 sick children occupy beds within our rooms and wards and that a similar number receive adequate care and treatment in the outpatient departments, the necessity for this much needed expansion needs no further emphasis.

J. S. W.

In and Out of Focus

BY THE OBSERVER

Time for Debate Has Passed

Many who were present at the meeting of the AMA's House of Delegates on December 5 when the House voted to undertake a national health program were highly elated. True, a few were assailed by doubts that there might be obstacles in the road of its realization. There was always the possibility that delegates voted for the program with reservations. Half-hearted efforts would certainly have ruinous consequences.

Developments since that meeting have not borne out these fears, but complications have ensued which are cause for concern. For example, at the Secretaries' and Editors' Conference held at the AMA's headquarters in

Chicago, February 8 and 9, there was considerable discussion as to the meaning of the portion of the report adopted by the House reading: ". . .The Committee recommends that the House of Delegates of the American Medical Association instruct its Board of Trustees and the Council on Medical Service and Public Relations to proceed as promptly as possible with the development of a specific national health program, with emphasis upon the nationwide organization of locally administered prepayment medical plans sponsored by medical societies."

To your Observer this statement is unmistakably clear. However, this was not the case with several others in attendance at the Conference. One group interpreted it to mean that the Board and the Council were instructed to develop a national health insurance plan. Others, that the House intended the organization of locally administered prepayment medical plans in all states and the District of Columbia, and that the task of the Board and Council would be to see that these plans are stimulated and coördinated.

It just so happens that your Observer had a hand in preparing the resolution introduced in the House by Dr. C. B. Conklin, Delegate from the District of Columbia, the "resolved" portion of which was incorporated in the report adopted by the House. He believes he understands what was intended in so far as the District Medical Society is concerned.

First of all, the House and the Council were instructed to proceed with the development of a specific national health program. That means an over-all program, not just a prepayment program. However, the resolution goes on to state "with emphasis upon the nationwide organization of locally administered prepayment medical plans sponsored by medical societies." Certainly there is nothing in this statement to imply that the AMA shall sponsor a national health insurance plan. In fact, what your Observer had in mind was that the Council should stimulate and assist with the organization of prepaid medical plans in every state and the District of Columbia.

He later suggested to the Chairman of the Council the desirability of establishing a Federation of Medical Plans. Representatives of the Federation should, he believed, meet periodically to discuss mutual problems and to evaluate the experience which had been gained.

Now all this is not too serious, but it might become so. The important thing is that medical leaders get together on a national health program. This is no time for stalling. Time for debate has passed. What we need now is action.

While your Observer was writing these lines, word came that Dr. Roger I. Lee, President of the AMA, had announced the Association's program. It appears from the following that differences of opinion have been ironed out.

"The Board of Trustees of the American Medical Association and the Council on Medical Service of the American Medical Association at a meeting just completed in Chicago have taken a long step toward protection of the American people against the costs of sickness through participation in a voluntary prepayment sickness plan now developed under the authority of the American Medical Association.

"The fundamental step in the development of this plan was the establishment of standards of acceptance for medical care plans which have the approval of the Council on Medical Service of the American Medical Association. Any plan which meets the standards of the Council will be entitled to display the seal of acceptance of the American Medical Association on its policies and on all of its announcements and promotional material. In order to qualify for acceptance, the prepayment plan must have the approval of the state or county medical society in the area in which it operates. The medical profession in the area must assume responsibility for the medical services included in the benefits. Plans must provide free choice of a qualified doctor of medicine and maintain the personal, confidential relationship between patient and physician. The plans must be organized and operated to provide the greatest possible benefits in medical care to the subscriber.

"Medical care plans may be in terms of either cash indemnity or service units, with the understanding that benefits paid in cash are to be used to assist in paying the costs incurred for medical service. The standards also include provisions relative to the actuarial data that are required, systems of accounting, supervision by appropriate state authorities and periodic checking and reporting of the progress of the plan to the Council.

"Coincidentally with the announcement of these standards of acceptance, there was organized, as a voluntary federation, an organization known as Associated Medical Care Plans, Inc. This independent association will include as members all plans that meet the minimum standard of the Council on Medical Service of the American Medical Association. The Associated Medical Care Plans will undertake to establish coördination and reciprocity among all of these plans so as to permit transference of subscribers from one plan to another and use of the benefits in any state in which a subscriber happens to be located. Under this method great industrial organizations with plants in various portions of the United States will be able to secure coverage for all of their employees. Moreover, it will be possible for the Veterans Administration, welfare and industrial groups as well as government agencies, to provide coverage for the people in any given area through a system of national enrollment. In addition, the Associated Medical Care Plans, Inc., will undertake research and the compilation of statistics on medical care, provide consultation and information services based on the records of existing plans and engage in a great campaign of public education as to the medical service plan movement under the auspices of state and county medical societies.

"The Board of Trustees of the American Medical Association also announced the establishment under its Council on Medical Service of a Division of Prepayment Medical Care Plans with a director and a staff who will administer the activities of the Council on Medical Service related to the promotion and development of medical care plans in all of the states.

"In announcing its proposals for a nation-wide provision of sickness insurance on a mutual nonprofit basis, the Association through its President and the Board of Trustees authorizes the publication of its complete health program with the ten points, which include the development of services in the field of preventive medicine, maternal and child health, voluntary prepayment plans for protection against the costs of sickness, compensation for loss of wages due to illness, the care of the veteran and the development of a high standard of housing, nutrition, clothing and recreation. The American Medical Association last June through its Board of Trustees and Council on Medical Service announced a 14-point program to improve the health and medical care situation in the United States. In October 1945 the interpretation of these 14 points and methods of implementation were adopted by the Council on Medical Service. In December 1945, the House of Delegates approved the whole program, suggested its rearrangement and directed the Board of Trustees to keep the program constantly up to date so that it will stay at least even with and, if possible, a step ahead of the needs of the public.

"With this in mind the Board of Trustees has adopted a restatement of the 14-point program, which clarifies still further the position of the American Medical Association on some of these points and brings into the program more definitely such matters as maternal and child welfare, medical research, the medical care of the veteran and the part to be played by the voluntary health agencies."

Then follows a restatement of the Association's 14-point program:

"1. The American Medical Association urges a minimum standard of nutrition, housing, clothing and recreation as fundamental to good health and as an objective to be achieved in any suitable health program. The responsibility for attainment of this standard should be placed as far as possible on the individual, but the application of community effort, compatible with the maintenance of free enterprise, should be encouraged with governmental aid where needed.

"2. The provision of preventive medical services through professionally competent health departments with sufficient staff and equipment to meet community needs is recognized as essential in a health program. The principle of federal aid through provision of funds or personnel is recognized with the understanding that local areas shall control their own agencies as has been established in the field of education. Health departments should not assume the care of the sick as a function since administration of medical care under such auspices tends to a deterioration in the quality of the service rendered. Medical care to those unable to provide for themselves is best administered by local and private agencies with the aid of public funds when needed. This program for national health should include the administration of medical care including hospitalization to all those needing it but unable to pay, such medical care to be provided preferably by a physician of the patient's choice with funds provided by local agencies with the assistance of federal funds when necessary.

"3. The procedures established by modern medicine for advice to the prospective mother and for adequate care in childbirth should be made available to all at a price that they can afford to pay. When local funds are lacking for the care of those unable to pay, federal aid should be supplied with the funds administered through local or state agencies.

"4. The child should have throughout infancy proper attention including scientific nutrition, immunization against preventable disease and other services included in infant welfare. Such services are best supplied by personal contact between the mother and the individual physician but may be provided through child care and infant welfare stations administered under local auspices with support by tax funds whenever the need can be shown.

"5. The provision of health and diagnostic centers and hospitals necessary to community needs is an essential of good medical care. Such facilities are preferably supplied by local agencies, including the community, church and trade agencies which have been responsible for the fine development of facilities for medical care in most American communities up to this time. Where such facilities are unavilable and cannot be supplied through local or state agencies, the federal government may aid, preferably under a plan which requires that the need be shown and that the community prove its ability to maintain such institutions once they are established. (Hill-Burton bill)

"6. A program for medical care within the American system of individual initiative and freedom of enterprise includes the establishment of voluntary nonprofit prepayment plans for the costs of hospitalization (such as the Blue Cross plans) and voluntary nonprofit prepayment plans for medical care (such as those developed by many state and county medical societies). The principles of such insurance contracts should be acceptable to the Council on Medical Service of the American Medical Association and to the authoritative bodies of state medical associations. The evolution of voluntary prepayment insurance against the costs of sickness admits also the utilization of private sickness insurance plans which comply with state regulatory statutes and meet the standards of the Council on Medical Service of the American Medical Association.

"7. A program for national health should include the administration of medical care, including hospitalization, to all veterans, such medical care to be provided preferably by a physician of the veteran's choice with payment by the Veterans Administration through a plan mutually agreed on between the state medical association and the Veterans Administration.

"8. Research for the advancement of medical science is fundamental in any national health program. The inclusion of medical research in a National Science Foundation, such as proposed in pending federal legislation, is endorsed.

"9. The services rendered by volunteer philanthropic health agencies such as the American Cancer Society, the National Tuberculosis Association, the National Foundation for Infantile Paralysis, Inc., and by philanthropic agencies such as the Commonwealth Fund and the Rockefeller Foundation, and similar bodies have been of vast benefit to the American people and are a natural outgrowth of the system of free enterprise and democracy that prevail in the United States. Their participation in a national health program should be encouraged and the growth of such agencies when properly administered should be commended.

"10. Fundamental to the promotion of the public health and alleviation of illness are widespread education in the field of health and the widest possible dissemination of information regarding the prevention of disease and its treatment by authoritative agencies. Health education should be considered a necessary function of all departments of public health, medical associations and school authorities."

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Medical Relations Upon invitation your Observer participated in the Middle Atlantic States Regional Conference of the AMA's Council on Medical Service and Public Relations held in Philadelphia on January 31. The subject assigned to him was the District of Columbia Public Relations Program.

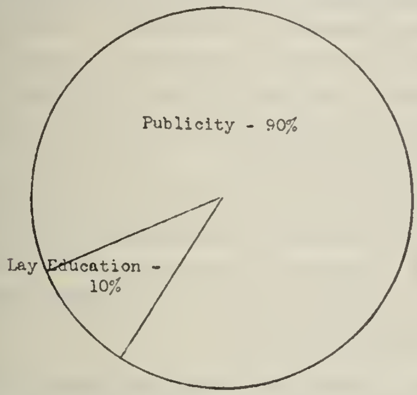
Some of his observations may be of interest to readers of this column, for they reflect his conclusions after many years of experience. First of all your Observer presented three charts which are reproduced on the next page.

Number 1 can be summed up in two words, "good publicity." But good publicity, important though it is, is only one element in a sound public relations program. If an attempt is made to foist pure propaganda on the press they are naturally resentful and, of course, not interested. For the aim of a newspaper is to present news objectively. This ideal unfortunately is not always attained. Nevertheless, it is a grave error for a group to proceed on any other assumption.

In numbers 2 and 3 the various activities which make up a public relations program are shown. The shaded portion labeled "medical relations" will be noted. It will be observed that only 10 per cent of the effort in 1940 was

CHART 1

The Average Physician's Conception of an Effective Program



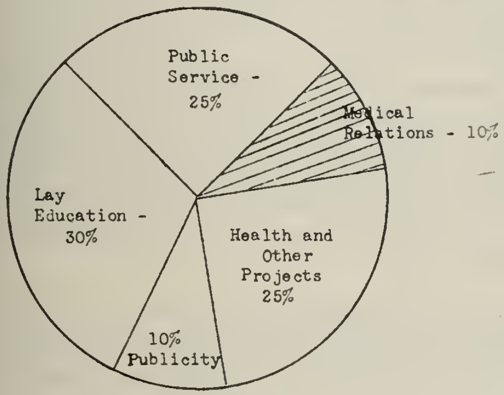
DISTRIBUTION OF EFFORT

Publicity 90%
- Favorable News Articles
- Favorable Newspaper Editorials

Lay Education 10%
- Health Talks
- Radio Broadcasts
- Health Articles for Newspapers

CHART 2

Prewar Program (1940)



DISTRIBUTION OF EFFORT

Publicity 10%
- Newspaper Releases
- Press Conferences
- Interviews
- Pamphlets

Lay Education 30%
- Public Meetings
- Health Talks (Speakers' Bureau)
- Radio Broadcasts
- Public Health Programs

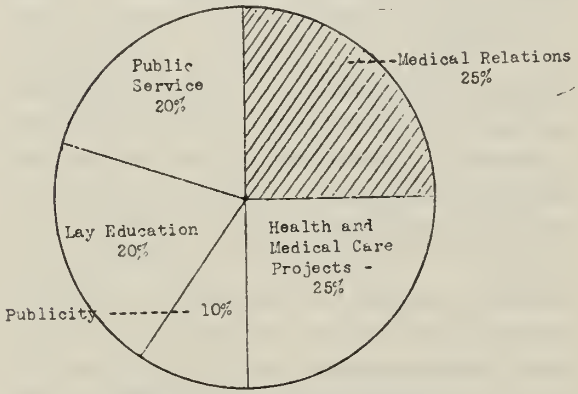
Public Service 25%
- Operation—Information Center
- Arbitration—Complaints Against Physicians
- Civic Participation

Medical Relations 10%
- Non-medical Meetings
- Non-medical Material in Medical Journal
- Communications

Health and Other Projects 25%
- Medical Care Plan for Indigent
- Joint Programs with Health Department
- Joint Programs with Social Agencies
- Joint Programs with Selective Service
- Public Health Activities

CHART 3

Postwar Program (1946–47)



DISTRIBUTION OF EFFORT

Publicity 10%
- Newspaper Releases
- Press Conferences
- Interviews
- Pamphlets

Lay Education 20%
- Public Meetings
- Health Talks
- Talks on Medico-socioeconomic Subjects
- Radio Broadcasts

Public Service 20%
- Operation—Information Center
- Arbitration—Complaints Against Physicians
- Civic Participation

Medical Relations 25%
- Non-medical Meetings and Conferences
- Non-medical Material in Medical Journal
- Communications
- Bulletins

Health and Medical Care Projects 25%
- Joint Programs with Health Department and Other Health Agencies
- Medical Care Program
  - Medical Prepayment Plan
  - Group Practice
  - Diagnostic Clinic
  - Indigent

devoted to medical relations. In the proposed program for 1946-47, it is 25 per cent, or an increase of 15 per cent. Of course these percentages are merely estimates. They indicate the approximate effort which has been or it is proposed shall be extended in each phase of our Society's public relations program.

Now why the emphasis upon medical relations? The fact is that comparatively few medical men can discuss the economic and social issues affecting medicine intelligently. Frankly, many of them are not interested. This is a situation about which something must be done. Certainly there must be some way in which the importance of this phase of medicine can be brought home to the medical profession.

Splendid as the record of the medical profession is scientifically, this is not sufficient to overcome its unfavorable position in the controversy over the delivery of medical care. It should be obvious that a sound public relations program is founded on constructive action. A group taking a negative attitude is always vulnerable. However, too many physicians do not seem to comprehend this fact. They are content to rely upon their professional prowess.

Dr. Roy B. Henline, President of the Medical Society of the County of New York, recently said, "It is well for us to remember that ultimately the best interests of our calling must exactly coincide with the best interests of the public whom it is our privilege to serve. It is only as we are able to identify the welfare of the profession with the public interest that we can command the respect and support of the public for those attitudes and policies which we believe to be vital to the future progress and integrity of medicine."

★

"...Heartaches of This Motor Age..."

It is difficult for those who have arrived at middle age to realize that to many of the younger generation the horse and buggy is as remote as the ox and cart. Most of them have never seen a horse-drawn carriage except, perhaps, in the movies, at a horse show, or in some museum. But those of us who recall the days of slower locomotion have fond memories of the spanking bay and surrey. A buggy ride was usually very pleasant, and more often than not relaxing.

That the horse and buggy still has its points even in our highly mechanical age is the view of Dr. J. J. Lightbody, who writes in the *Detroit Medical News* for February 11, on the subject, "Bring Back the Horse."

> "In the good old days when Sears Roebuck catalogs were considered excellent material for 'outside' reading," Dr. Lightbody observes, "doctors had horses and carriages as means of transportation in making house calls and hospital visits. It was considered expedient for doctors to have dependable nags to pull those buggies to make sure they got to the spot just before the stork brought the little bundle of happiness. Many and varied are the stories of these early pioneers of medicine as they fought their way fiercely through storms, floods and blizzards to the bedside of a person who had a very bad cold. Occasionally the horse would fall dead or the carriage would disintegrate, but old Doc would get there in spite of hell and high water—never late—never early—just in time.
>
> "Nowadays, when the only thing that frightens a horse is the sight of another horse, we are experiencing the same pitfalls of transportation as our professional forebears, only instead of a simple horse and carriage we have a new gadget called an automobile—and it looks as if the darned thing is here to stay (if they ever start making 'em again)."

Despite hardships, the "good old days" were comparatively simple and carefree. At least we were not burdened with the thousand and one details common to modern life.

> "All that the hardy pioneer physician had to do was to make sure old Dobbin had a nosebag of oats twice a day, a few pails of water and an occasional lump of sugar, and his motor problems were solved," says Dr. Lightbody. "But what do we have now? We lie awake every night during the winter wondering whether that d—m car is going to start in the morning. The biggest moment of the entire day occurs after you have pounded your way out to the garage and jumped into the front seat of the car and put your foot on the starter—your heart leaps

> with joy as the cylinders gallop up and down in rhythmic ecstasy—then bang—boom—s-s-s-s—the motor gives one long expiratory wheeze and the smoke starts rolling out the exhaust pipe like it does out of the Edison smoke stacks. You wait a moment until the smog (smoke and fog) clears, and you slowly lift up the hood to examine something you don't know a thing about—sort of an exploratory motorotomy. After a quick look you decide everything is all right and you give another try and it starts all right, but the engine seems very noisy and you look around to see which side the cement is coming out. You then put the car in reverse and try to back out of the garage by rotating your head a full hundred and eighty degrees 'til you feel faint, and about that time the rear fender and the side of the garage get very intimate, so you force the issue and give 'er the gas, thereby removing the few last vestigial remains of a former paint job on an accordion pleated fender.
>
> "Then when you add all this to such minor items as leaky radiators, flat tires, broken distributors and worn out points, carbon on the valves (of Houston), octaneless gas, sludge in the bilge, blown mufflers, slippy clutches, sizzling gaskets, frigid air heaters, buckled batteries, sparkless sparkplugs, prolapse of the bumper and ptosis of the water pump—you got sumpin!
>
> "Oh, the heartaches of this motor age; give us less horsepower and more horse sense."

Dr. Lightbody concludes that "there can never be that mutual respect and understanding between the modern doctor and his auto that there was between the old doc and his horse—and furthermore, we don't know of anything they have ever swept out of a garage that did anybody any good."

★

The Doctor Got His Tires But—

Rationing will soon be only a memory. Local rationing boards have all but closed shop which, to individualistic Americans, is cause for rejoicing. For despite his patriotic desire to help win the war, John Q. Public chafed under innumerable restrictions. Remembered are the indifference and contempt shown him by those who often arbitrarily decided what he was or was not entitled to. What he said about public servants on occasions was not printable. Unfortunately, more readily forgotten are the faithful, conscientious ration board officials who showed him every consideration.

His feelings are eloquently expressed in an editorial entitled, "Thoughts of a Doctor While Awaiting Red Tape Unwinding in the Local O.P.A. Tire Rationing Office," which appeared in the November–December, 1945 number of the *Hawaii Medical Journal.*

> "He [the physician] had rushed through house calls the previous morning in order to have his badly worn tires inspected and approved for replacement," the doctor writes. "Between hospital rounds and office hours he had sandwiched in a visit to the O.P.A. office to arrange for the tire replacements.
>
> "He had arrived there at 8:45 a.m., only to discover that the O.P.A. office now opened up for business at 9:00. (Outside of government employees, most people he knew started the day's work by 8:00 or at least by 8:30; he had started at 6:30.) So he sat on the steps and waited, filling out a long and tedious questionnaire as he did so.
>
> "Then—although the inspector's report indicated his tires were dangerously worn—he was told no one in the office was qualified to pass on the application, but the Board (fortunately) was meeting that day and would consider the matter. He could return the next day for the necessary document which would permit a dealer to sell him tires. No, the office could not (or would not?) mail this to him; the doctor must make another trip ('was this trip necessary?') next day to pick it up.
>
> "So next morning—this was the third day—he postponed a house call on a sick child to revisit the tire rationing office. He could have saved time and mileage by stopping in on his way from one hospital to another had the office been open when most private business offices open; but it wasn't.
>
> "One of the office employees leisurely rose from her desk, took a final drag on her cigarette, put out the fire, snapped the butt through an open window, then asked what the doctor wanted.
>
> "She wasn't the lady he had talked with the day before, and expressed some astonishment when he said he had filed his application the previous day and expected a permit to buy tires today. 'Why, our Board just met yesterday afternoon!' Then, 'Oh, are you a doctor? Wait a minute.'
>
> "So he sat, while a couple of other girls rummaged through a foot-high stack of forms, questionnaires, and God-knows-what. (Just how did anything ever get done

back in the good old days before bureaus and bureaucrats developed their technic for producing forms and questionnaires?)

"And the doctor sat on a wooden bench and waited, and while he waited he mulled over in his mind the compulsory health insurance scheme which is part of the Wagner-Murray-Dingell bill now pending in Congress, and pondered on its implications.

"With the working of an office of a government bureau unfolding before his nose he couldn't help comparing two processes: (1) how he used to buy tires, and (2) how he bought them now. He used to call up a dealer of his choice and tell him he needed new tires. The dealer, glad to have his business, sent for the car, put on the tires, and sent in his bill; it was paid, and that was that. Now—well, the government had moved in between. With the rubber shortage, there was reason and need for it, to be sure. But when the government moved in, a simple process which used to take an hour or so now required three days, three two-mile auto trips, endless forms to fill out, the action of a board, and the functions of an office staffed with 'servants of the people' observing bankers' hours."

Having drawn a parallel between his experiences with the O.P.A., and what would occur if the Wagner-Murray-Dingell bill was enacted, the doctor observes that "all the delays, red tape, questionnaires and petty interferences . . . are part and parcel of about every governmental bureau one can name."

"Selling a political ideology to the masses under the old malarky that they are going to get something for nothing seems to be the order of the day," he says.

"There are even handouts to the doctors themselves in Mr. Wagner's bill, and some doctors will undoubtedly fall for them.

"Beware the politicians bearing gifts!

"Look all the way down a Trojan gift horse's gastrointestinal tract!"

★

Join the S.O.G.!

Some months ago your Observer talked with one of the younger members of the Society who, in the course of the conversation, remarked, "There isn't much chance for a young physician to do anything in the Medical Society. The same group runs it year after year. An outsider doesn't have a chance."

Of course this isn't true, so your Observer explained to this physician why he was in error. He told him how difficult it was to obtain the active participation of members, that comparatively few are willing to devote time and effort to the Society's activities. Most important, that all he had to do to obtain a committee assignment was to inform the President of his desire to serve. He was somewhat taken aback at this but said before the next President took office he would do as your Observer suggested.

Not only is it true that there are few physicians who will devote the time necessary to make a medical society a worth-while organization but those who do are frequently unappreciated. Too often, they find themselves objects of unjustified criticism. Fortunately, there are many satisfactions in serving the profession. If this were not so, medical societies would indeed be impotent. So, one can be pretty sure that physicians who are active in medical societies are, for the most part, inspired by unselfish motives.

Dr. Fred B. Kyger, President of the Jackson County (Kansas City, Mo.) Medical Society, recently made some interesting observations along this line.

"There are many reasons," Dr. Kyger says, "why policies are decided and acted upon by relatively few members. Suppose each year we would send a different delegate to the American Medical Association. It takes several years for a delegate to be known, and to even know what is going on. He would receive very few important committee positions and would be replaced just when he was becoming acquainted. Next, let us have a new Editor of the Bulletin each year and see how it would fare under new management, or have a new man represent us in council of the Missouri State Medical Association. Even now our delegates to the annual meeting of the Missouri State Association are many of them unfamiliar with the problems to be met, not because

> of any fault of their own, but because they are changed too frequently.
>
> "The reason for the 'same old gang' in an organization is that there are usually only a few in any group that are willing to give their time and effort in its behalf. It resolves itself down to the willingness of a member to work, and whenever that is demonstrated, he becomes a full fledged member of the S.O.G.
>
> "When I look around the Council table at the executive committee meetings which happen frequently and last often till late in the evening, I am thankful that we have so many busy men, interested enough to be part of the Same Old Gang. Let me assure you that anyone wishing to join this gang will find someone anxious to give him his place. Any information regarding the society will always be cheerfully supplied by the executive office."

And your Observer might add, "That goes for the Medical Society of the District of Columbia!" Doctor, why not join up!

* * *

Plea for the Scientific Approach

One thing alone would be sufficient to commend the National Conference on Medical Service which met in Chicago on February 10, that is, its policy of presenting both sides of the question, no matter how controversial the subject. It is to be regretted that this is not done more frequently by other medical groups. True, some state medical societies have not hesitated to do so, but there are still too few of them.

Mr. Nelson Cruickshank, one of the speakers at the recent Conference, presented the American Federation of Labor's views on medical care. As might be expected, he advocated the enactment of the Wagner-Murray-Dingell bill. Although your Observer disagreed with him on several points, there is no denying the fact that Mr. Cruickshank presented his side of the case ably. Among other things he pleaded for the scientific approach to the issues involved. He said quite properly that reason rather than emotions should govern physicians in the consideration of them.

It is your Observer's plea, too, that doctors examine and evaluate the problems relating to the delivery of medical care objectively. Understandably this is not easy for them to do. For aside from the larger issues, personal interests are involved. How will changes affect their professional lives? Will they necessitate their beginning them anew? These and many other considerations stir the emotions. Unfortunately this situation does not arouse their curiosity sufficiently to stimulate a dispassionate investigation of the facts. And certainly, as Mr. Cruickshank says, this is an unscientific approach.

All physicians who are informed with respect to controversial medical issues recognize the fact that all is not well with medicine. For there are serious deficiencies in present methods of delivering medical care. It is obvious to them that a remedy must soon be found. This is not possible unless doctors remember that they are, or should be, first and always scientists seeking the truth.

* * *

Washington Post's Poll

"An overwhelming majority of District residents support President Truman's plan for national health insurance." Thus the *Washington Post* sums up its recent poll of residents of the Nation's Capital.

The question which the *Post* asked "the representative cross-section of the city's population" was this: "The President has suggested that a small amount be paid from a worker's wages into an insurance fund that would help pay doctor, dentist and hospital bills for the worker and his family. Do you approve or disapprove of the plan?" An analysis of the replies to this question show that 70 per cent approved, 21 per cent disapproved, and 9 per cent didn't know. Of the 21 per cent who disapproved, the following reasons were given: "Too much deducted from salaries now," 30 per cent; "Will lead to socialized medicine," 17 per cent; "Want to select own doctor," 17 per cent; "Too much coddling," 15 per cent.

Your Observer has no quarrel with the question asked, except that those questioned were apparently not told that the insurance fund would be administered by a Government agency. At least there is no such inference in the question. Whether the result would have been any different, he does not know. But the experience which people have had here and elsewhere during the war with Government supervision of their daily lives would, in your Observer's opinion, make those polled think twice before agreeing that the care of their health should be other than a private affair.

Elsewhere in this month's column, experiences with ration boards are described. Now, a national health insurance system might be much more efficient than the O.P.A., but there is some justification for skepticism. Certainly there would have to be restrictions and many more controls than the proponents of this program are willing to admit. It would be far better, in your Observer's opinion, to give voluntary insurance a real trial than to turn the job over to the Government. At least if the voluntary system should prove unworkable, the time lost would be more than compensated for by the experience gained.

* * *

". . . an Experiment in Teaching . . ."

"In these days when technical advance holds the center of the stage, most medical students have little opportunity to learn about either the relations between physicians and society or those between economics and disease. Few are able to approach the social or economic problems of the profession with the same intelligent attitude with which they face illness. Their education has been excellent from the technical point of view, but many of the fundamental problems besetting the profession of which they are about to become members have not been mentioned. Only a few students have interested themselves in these matters outside their studies."

Thus the *New England Journal of Medicine* (January 3, 1946) expresses views long held by your Observer. In his opinion it is nothing short of inexcusable neglect to permit students to enter medical practice without instructing them in such practical matters as office management, adequate records, and financial relations with patients. Equally deplorable is the failure to give them an objective view of social changes affecting medicine.

With respect to the latter, there recently appeared in the MEDICAL ANNALS a splendid editorial by Dr. Donal Sheehan, Acting Dean, New York University School of Medicine, who said, "The education of the physician of tomorrow can scarcely be considered complete without a knowledge of the medical needs of the people, probable costs, and the various means by which the costs can be defrayed.

> "The medical student needs further a background of the greatness of the history of his own profession, so that he may have a faith in its future. He needs insight into his position in society, the aims of his profession, its hopes and problems. He needs to know how he may best fit into the world he is to face. He needs to be an educated man in order to enjoy the respect which will make possible the most effective use of his medical knowledge. These aspects of the medical student's preparation for life are now all but lost sight of, the students being allowed to learn these things by hard experience or not at all."

Dr. Sheehan proposed that there be established in his medical school a Department of the Humanities in Relation to Medicine.

What is described by the *New England Journal of Medicine* as "an experiment in teaching" has recently been undertaken by the Harvard Medical School. A series of nine lectures was given to third-year students during the year 1945 under the auspices of the Department of Preventive Medicine. The first of these lectures was devoted "to the broad problem of the individual as a social being and to the effect of social and environmental factors on his health."

Ida M. Cannon, formerly chief of Social Service at Massachusetts General Hospital, described the role of the medical social worker as follows:

> "It is not the function of the medical social worker to take over all the social responsibility for care of the patient. The patient is the responsibility of the physician. The more aware the latter is of the significance of social factors in the patient's life as they may bear on his illness, the more readily will he make suitable use of the assistance of the social worker. He turns to her to elaborate the brief—too brief—social study of the patient and to assist him and the patient in working out a practical plan supportive of his medical-care plan.
>
> "What are some of the methods of securing pertinent social information? One principle we must accept is that of individualizing the patient. For the patient this is entirely acceptable. The patient feels unique; he is unique. We can lose ourselves in the group in some situations,—ball games or symphony concerts,—but in illness we are unique. The feeling of the patient about his illness—its meaning to him—is then of first importance.
>
> "The trained medical social worker disciplined by working closely with expert clinicians has special reason to appreciate some scientific procedures and principles. She is trained to case study in the area of the social life. She keeps in mind the common need for a normal, satisfactory way of life—namely, satisfying family relations, health, economic independence with good occupational adjustments, freedom in recreational activities and a reasonable degree of fulfillment of one's wishes and interests. The patient's so-called 'social situation' prior to illness and as affected by illness is of concern to the medical social worker. She must determine what aspects of this situation may be significant to the physician. The gathering of such data from the patient, his family and others, the correlation of them to the clinical findings in conference with the physician, and planning with the patient and the physician to make available to the patient her experience and resourcefulness are her suitable functions."

Miss Cannon concludes:

> "It is easy to accept the principle that the patient's personal and social situation should be taken into account in the treatment of his disease. It is not so simple to put this into practice in medical care in our busy, modern hospitals and clinics. Time limitation is a serious factor. Focus of attention on pathology, with due consideration given to minutiae, is time-consuming and tends to limit the area of attention, to the exclusion of a breadth of view. In the light of the vast realm of medicine, we must accept the necessity for specialization, with its deepening and enrichening of knowledge and of skills for merciful purposes. Specialization in the social aspects of medicine has come as a logical development of clinical specialization and the necessary organization of services to large numbers of patients in the present-day institutional practice of medicine."

The broadening of medical education to embrace subjects related to the society in which we live is most encouraging. Let us hope that all medical schools throughout the country will take note of the progress being made in this direction.

★

Hangover Headaches It is a quirk of human nature that things which make us most miserable are often a source of amusement to others. Witness the hilarity of movie audiences when a seasick passenger rushes for the ship's rail. A dangerous fall is always good for a belly laugh. But nothing, it seems, is as amusing as the affliction commonly called a hangover.

These reflections followed the discovery of an article entitled, "A Survey of Hangover Headaches," appearing in the December 1945 issue of *The Journal of the Louisiana State University School of Medicine*. The author, who prefers to remain anonymous, joins the less erudite in making sport of the unhappy consequences of overindulgence.

> "The hangover headache," he says, "is a singular phenomenon which merits a leading place in any symposium on headaches. Here at long last we find an exceedingly common disorder with known etiology; of course if we could term it idiopathic it would be much better sounding 'doctor talk.' But this is a discussion between us medical men of science and we have no need for trying to impress one another. This headache has a strange predilection for occurring on Sunday mornings but shows no sex frequency. In former years it was supposed to occur only in the male but recent evidence would seem to show that this sex incidence was merely the result of failure to diagnose correctly the cases in females who were wont to disguise their debauchery as 'female weakness.' "

As to the causative factors, symptoms and other features of hangover headaches, the author says:

"The etiologic agent may have varied by name down through the ages but in substance it has never changed—the ancients had their ambrosia, the Vikings had their mead, the English their ale, the Germans their schnapps, the Russians their vodka, the Indians their firewater, Hairless Joe and Lonesome Polecat their Kick-a-poo Joy Juice, and we have Larry and Katz and their Early Times. Massive doses of any of these fluids the night before is sufficient cause for hangover headache the morning after (this is an important point in diagnosis and all juniors and seniors with little black books should make a careful notation of this fact—Med. Diag. Clinic) . . .

"Persons suffering from hangovers present a multiplicity of symptoms which vary greatly between individuals, but which show a peculiar constancy in the same individual. Investigation has shown that these headaches have a marked tendency to weekly exacerbations and remissions. This tendency is more pronounced in some patients than in others and there is a periodic increase in the number of cases seen which seems by some unexplained mechanism to coincide with social functions at the Jung Hotel sponsored by various fraternal groups among the medical profession. Patients will almost unanimously state that their troubles began with a tremendous inability to get out of bed the morning after a big night. The other complaints are variable but they will be numerous. All will complain that their cranium feels as if it contains an expanding barrage balloon rattling its chains. Sometimes it will feel as if they are having clonic contractions of the cerebrum. This throbbing pain in the head is usually frontal and the eminent research man in this field, Danniel Boud, states that any excitement or movement exaggerates the pain; in experiments on himself he finds that he 'Likes to squinch his eyes and exclude all external stimuli.' Another prominent self-experimenter, Victor K. Youthful, found that he ached all over and 'Wanted to die.' This of course must be taken to be an extreme case, although other workers have reported patients commonly swear never to touch another drop. Upon occasion a sentimental quirk of mind is to be noticed; an example of this was reported by Legrand J. Serf who experienced a desire for a soft lap to lay his head on.

"The appearance of a person with a hangover headache is quite characteristic; he is usually to be seen sitting or lying motionless by the hour, with a 'mask-like unwinking reptilian facies.' The features are waxen and plastic, and the lack of movement suggests bilateral hemiplegia. This external immobility is in direct contrast to the sufferer's description of what is going on inside of him. The medical student suffering from a hangover is often reminded of Bang's disease by the resemblance between his symptoms and those which might be produced by a phlebolith in the Circle of Willis. The literary student has visions of Alice in Wonderland's walrus leading the oysters through every nook and cranny of his head with the rough-edged shells grating about like people in a subway. And everybody, student or not, has this headache which is intensified by stooping, coughing, or straining at stool."

"The prophylaxis of hangover headache is a problem which has received much attention for many centuries. Since time immemorial favorite methods have been brought forth to turn the trick. Cicero once wrote, 'If you want to drink a good deal at a. . .convivial party, eat as much cabbage raw as you like with vinegar beforehand . . . this will have the effect that you will show no signs of liquor on the breath or otherwise, however much you drink.' And Aristotle in his writings 'enquires as to the cause of this amethystic (aside to pharmacology students. . .from the Greek, A-without; methuo-intoxicate) quality' of cabbage. Present day knowledge of prophylactic is not much further advanced although it is hoped that streptomycin will work here, too."

★

On Writing Editors of state medical journals have many problems in common. One of them is the difficulty of obtaining good scientific papers. Usually they have to rely upon papers which have been presented at scientific meetings. Not all of these are worthy of publication, but somehow the space must be filled. Where does the difficulty lie?

There are undoubtedly several reasons for this state of affairs. One may be that doctors generally do not have much to say. Then there is the time factor. Physicians feel themselves too busy to take the time to write a scientific article. Then, too, there is the distaste for the drudgery of writing which perhaps is the primary reason. If the physician wishes to write well, he must like to do it, for in writing as in speaking practice makes perfect. In fact, the only way to acquire skill is by constant and unremitting effort.

Your Observer does not pose as an authority nor an expert in this field. However, he can honestly say that if not too pressed he enjoys his

(*Continued on page 150*)

Washington Physicians of Yesterday

ALEXANDER YELVERTON PEYTON GARNETT, M.D.

Able, colorful, and courageous, Dr. Alexander Yelverton Peyton Garnett was one of Washington's most distinguished physicians. He was highly regarded by his contemporaries for his professional skill.

Born September 19, 1820 in Essex County, Virginia, he entered the University of Pennsylvania as a student of medicine, graduating in 1842. Immediately thereafter, he became Assistant Surgeon in the Navy of the United States. In 1849 he resigned his commission and entered private practice.

Believing that his first allegiance was to Virginia, he left Washington upon the outbreak of the Civil War and proceeded with his family direct to Richmond where he entered the service of the Confederacy. He became family physician to President Jefferson Davis, General Robert E. Lee, and nearly every member of the Confederate Cabinet and Senate.

At the close of the war Dr. Garnett visited Washington. His former patients and many friends urged him to return to the Nation's Capital, which he did.

Dr. Garnett was President of the Medical Association of the District of Columbia in 1882–83, President of the Medical Society of the District of Columbia in 1884, and President of the American Medical Association in 1887.

Dr. A. Y. P. Garnett, a grandson, is now one of Washington's best known physicians.

Dr. Garnett died on July 11, 1888 at Rehobeth Beach, Delaware.

Military Affairs

A "PSYCHIATRIST-AT-LARGE" IN JAPAN

Z. M. Lebensohn, M.D.

Commander, Medical Corps, United States Naval Reserve; Assistant Professor of Clinical Psychiatry, Georgetown University School of Medicine

On a recent trip to Tokyo, about a month after the occupation, I had an unusual opportunity to visit a Japanese medical school and teaching hospital. Our interpreter and guide was an excessively polite and immature-looking college student named Taro. He had agreed to take us to Keiō University Medical School where his cousin was in his third year. Keiō University houses one of the seven large medical schools in Tokyo and is located in a section called Yotsuya, about 5 miles from the center of the city in a semi-residential district.

As we entered the grounds we noticed that many of the buildings had been damaged or destroyed. We were later informed that a third of their buildings including the section for first class patients had been burned to the ground. Another third was seriously damaged and the remaining third was untouched. We were ushered into the library building, a memorial to one of their distinguished alumni, and introduced to Dr. S. Uiematsu, Professor of Neurology and Psychiatry, and a graduate of Harvard University Medical School, class of '22. It was shortly after twelve noon and the faculty was just finishing lunch in a large conference room, richly paneled in dark wood. Professor Uiematsu introduced us to the rest of the faculty and apologized for the absence of the dean who was out of the city. He showed us to chairs in an adjoining reception room and invited us to have luncheon. Being aware of the serious food shortage in Japan we declined his hospitable gesture, but he called for a pot of Japanese tea in which we all joined. In turn we offered him some American cigarettes which he smoked with obvious relish.

The professor was a small, serious man of about 50 with a tiny moustache and greying hair. He wore the conventional thick glasses and was dressed in a conservative tweed of American cut. His English was a bit slow and soft spoken, but his choice of words was exact. He spoke of his psychiatric training under the late Dr. Macfie Campbell with more than a trace of nostalgia. He looked rather subdued and sad as if to imply that the happenings of the last ten years were not of his choosing. He was very dignified, attentive, and polite to us as visitors, but there was none of the fawning and obsequious behavior which appears to be so prevalent among the conquered Nazis. We talked as colleagues and he answered all questions willingly and apparently without reserve.

We spoke first of psychiatry. He told us that the Japanese psychiatrists had anticipated a large number of psychiatric casualties following the B-29 bombing raids. They received only one half the estimated number among the civilian population. (This is strikingly similar to the British experience as reported by Colonel Gillespie.) There has been no relative increase in the incidence of psychoses in either the civilian population or in the armed forces. This, too, appears to be a universal experience. When I inquired about the incidence of psychoneuroses in the armed forces he smiled wryly and stated that, of course, they occur, but are not called by that name for reasons of military expediency. He felt that there was perhaps a slight increase in the incidence of general paresis during the war but practically no other changes in the incidence of psychiatric illnesses.

The Japanese have been familiar with all the recent forms of shock therapy and are still using insulin in schizophrenia, particularly in the catatonic form. When I asked if he followed the Sakel technic he seemed to be unfamiliar with the name and did not know that Sakel had introduced insulin shock therapy over ten years ago. This was explained by the fact that all the recent European medical literature available in Japan was of Nazi origin. Since Sakel was a Viennese Jew, his name had apparently been carefully deleted from all the literature on insulin therapy. Professor Uiematsu mentioned that the Japanese had been using an insulin derived from fish pancreas which was found to be very effective in producing hypoglycemia. This is not too surprising when it is remembered that Japan is not a meat-eating country but depends chiefly on fish for its animal protein.

Metrazol (or Cardiazol, as it is known in Japan) was used in 1938 and '39 but for the last 5 years electroshock therapy has been employed. It is still being used with considerable success in the treatment of the depressions. On inquiring further I learned that all treatments are given in hospitals; none is given in homes or outpatient clinics. Curare has not been used to cushion the shock of the convulsion, and, in fact, he was ignorant of its use in this regard.

Prefrontal lobotomy has been performed on a large series of cases by Dr. Nakada of Niigata University Medical School. Many of the cases were, surprisingly enough, manic-depressives in the manic phase. His results were apparently encouraging enough for him to continue with the operation. He uses the lateral approach with a simplified leucotome similar to that used by Freeman and Watts.

Psychoanalysis has apparently very little following in Japan. Professor Uiematsu could think of only one psychiatrist practicing analysis. This psychiatrist had also studied in the United States with Dr. Adolf Meyer shortly after World War I and is still practicing in Tokyo.

I asked Professor Uiematsu about his experience with sodium amytal or pentothal narcotherapy. Not only had he never used it, but he was quite unaware of its value in military and civilian psychiatry. He exhibited great interest in the subject and I referred him to a few of the leading articles in some of the American journals to which he might soon have access and he was very grateful.

We also questioned the professor on more general medical topics. He said that malnutrition was Japan's most pressing problem. Despite this, there were very few cases of beri-beri and practically no cases of deficiency polyneuritis. This is eloquent testimony to the efficacy of the governmental edicts insisting on the use of unpolished rice in the diet. Tuberculosis is definitely on the increase, and postoperative wound infections are numerous because of the decreased resistance of the patient and the breakdown in aseptic technics in the understaffed and bomb-shattered hospitals.

Professor Uiematsu next showed us through the Keiō University Hospital, which is the teaching hospital in direct connection with the medical school. They used to take in three classes of patients but now have facilities for only the lower two classes since the building housing the first class patients was destroyed. The third class patients pay 4 yen (about 60 cents) per day and the second class patients pay 8 to 10 yen. Despite a large number of white-gowned orderlies and nurses, the floors and walls of the third class section were filthy, and the ward smelled bad. Someone had started to burn some fragrant charcoal in a porcelain urn, but this did not help matters appreciably. Each bed was separated from its neighbor by dirty white sheets which were kept draped about the bed all day giving each patient a certain amount of privacy. The relatives of the patients, who were present in large numbers, were either hovering anxiously about the patient or running up and down the narrow corridors on various errands adding immeasurably to the confusion. The beds were of the standard hospital type, but in each cubicle the patient usually had some prized household objet d'art—a doll, a figurine, or some treasured possession—on a prominent place near him.

In the large tiled bathroom and toilet (only one on each floor for both sexes) we found a Japanese woman busily engaged in building a twig fire on the floor to warm some home-made food she had brought for one of her relatives. This practice is no longer uncommon and, in fact, is encouraged by the hospital since it is almost impossible for the institution to scrape together enough food to feed its patients adequately. The washroom was large and well designed but was suffering from neglect. The toilets or "benjos" were of the characteristic Japanese variety, built almost flush with the floor and shaped like a miniature porcelain gondola with a splash-proof prow. In Japan one must be able to squat with agility and accuracy.

We were taken next to the psychiatric wing for second class patients, the only facilities remaining. There was room for about 20 patients but only 10 rooms were occupied. These were quite elegant in comparison with the accommodations for the third class patients. Each patient had a large private room which appeared to be decorated and arranged according to the individual taste of the occupant or one of his relatives. A large section of the room was raised about 8 inches to make a platform which was covered with finely woven straw matting. Part of this raised platform was used as a bed by the patient who lay covered with beautiful thick comforters in richly colored silks. Some of the patients had their own furniture moved in to make things more homey. A distinguished and elaborately robed man of 50 sat cross-legged on the floor in front of an ornate kakemono scroll, a case of presenile psychosis. A lady in a room across the hall lay in bed completely mute, her unseeing eyes fixed in the typical expression of catatonia. A third patient in his 50's was being treated for general paresis by typhoid injections. Therapeutic malaria is usually employed, but in this case Professor Uiematsu felt that the patient was too old and feeble to withstand such rigorous treatment.

We made a brief tour of the remaining parts of the hospital. The laboratory was a large but poorly kept room full of dirty glassware and antiquated apparatus. In one corner were several bottles of mold-covered urine which had apparently been standing for days. Everything looked rundown, dirty and neglected. The pharmacy contained a few glass jars of old drugs and herbs. Even these were meager in quantity, and the doctor complained bitterly that it was almost impossible to get essential drugs and medications. I commented that the caves honeycombing the hills near the Japanese Naval Hospital at Yokosuka were crammed to the top with fine instruments and drugs, mostly of German manufacture. He smiled sadly and said, "Ah yes, for the military there was never any shortage." The large operating room contained 2 tables of fairly modern design, but the wall plaster was badly cracked and huge flakes of old paint threatened to fall from the ceiling. The X-ray equipment was all antiquated and it was impossible to get replacements for worn parts.

As we walked down the stairs, we noticed that all the metal treads had been removed from the edges of the terrazzo steps. When I inquired about the reason for this the professor smiled and said quite slowly, "They went into our last big scrap drive—over a year ago!"

LETTERS FROM MEMBERS IN THE SERVICES

From Lt. Commander Jack L. Derzavis, c/o Fleet Post Office, San Francisco, Calif.:

Dear Ted: I've been in the service for forty-four long months and during that time we have corresponded with some semblance of regularity; I, usually, to gripe or ask a service of you, you always acceding promptly to every request and continuing to send me your grand morale buoying letters, and I am very grateful. Now the time has arrived for me to return home so here is a last note before I drop into the office for a personal chat.

Your letter of January 2, like all the others, was interesting and informative. I gather that our town is not yet the pleasant unblustered place we enjoyed before hostilities began, but I recall my postwar childhood of the early twenties clearly enough to hope a similar pattern of return to normal will occur. However, Washington has become the Capital of the world and much of the newly-burgeoned-forth building and population will remain. We shall no longer be able to maintain our old conservative complacency of normal growth and development and I wonder how much our lack of voting power will prevent our civic progression. I am anticipating more activity for all of us who look upon Washington as home as well as a place of livelihood. I hope the Medical Society will play its part well and fully in the future which is ours to make.

Duty out here in the New Hebrides has not been unpleasant. And, now that I shall leave for home sometime early next month, I have been relaxing, fishing, exploring and reading. The thought of once more being with my wife and little daughter and family is one of ineffable joy. I am hoping too that return to practice will be as pleasant as I anticipate, the dearth of office space notwithstanding.

From Captain Percy A. Bryant, c/o Postmaster, San Francisco, Calif.:

Dear Mr. Wiprud: I have just received and read your newsletter dated January 2 and I must say I enjoyed it very much.

There have been a lot more fortunate than I who have got home and are discharged. I, too, thought I would be on that list in November when I was put on orders to go home. After spending 16 days in a conval. camp waiting for a ship, I was told I was not going home after all. You can imagine my disappointment. I was reassigned because of my specialty rating and will now have to serve until I have completed 45 months' service. My time will be up in May and after then I hope to get orders reading "Home."

The office space shortage has given me considerable concern but I certainly hope by the time I get back it will have improved and all of us can find offices.

From all reports about Washington it really has been a cold winter. It's hard to believe it could be so cold there while it is so hot here in Saipan. If I get home in the summer it will be more like this kind of weather.

I look forward to the newsletters and hope you will see fit to keep them coming to us, the unfortunates who are left overseas.

PRECEPTORSHIPS IN OPHTHALMOLOGY

In regard to the substitution of a preceptorship for residency in an ophthalmic hospital, the American Board of Ophthalmology has always accepted such training in favorable cases. During the present overcrowding of facilities, the Board expects to take a liberal attitude regarding the requirements for training.

It should, however, be pointed out that neither a residency nor a preceptorship suffices in itself to meet the requirements of the Board. Each case will still be judged on its merits in determining fitness for examination.

In entering upon preceptorship certain conditions should be kept in mind. First, the student will profit most after a sound course in the basic sciences of physiology of the eye and of vision, optics, pathology, bacteriology, chemistry, pharmacology, the relation of the eye to general disease, anatomy, embryology and neurology.

This is essential for a residency, more so for a preceptorship. While men have been accepted from preceptors not diplomates of the Board, it is obvious that the Board has more information about those teachers who have passed its examinations.

Any preceptor should understand that he is assuming a responsibility in taking a student and is not merely obtaining help in the drudgery of his office. He should be willing to give time to clinical training and the use of apparatus, slit-lamp, ophthalmoscope, tonometer and to directing the student's practice in surgery on animal eyes, assisting in operations and ultimately in the performance of them.

To cover the same amount of ground will take much longer in a preceptorship than in a residency and students should accept opportunities to take hospital positions of all sorts as they become available.

S. JUDD BEACH, M.D.
Secretary, American Board of Ophthalmology

MEMBERSHIP

The following applicants for membership will be voted on at the meeting of the Executive Board, March 25, 1946:

Active Members

Leonard Stanley Berman, George Washington University—1936
Samuel Burtoff, Hahnemann Medical College—1943
William J. G. Davis, University of Maryland—1943
Marcel Jean Foret, Louisiana State University—1939
Armand B. Gordon, George Washington University—1938
Jaye Grollman, University of Maryland—1938
Samuel A. Hillman, George Washington University—1938
Bernard Katzen, George Washington University—1938
Israel Kessler, Temple University—1934
Charles E. Law, George Washington University—1939
Jack Louis Levine, George Washington University—1938
Eugene G. Lipow, University of Illinois—1932
Harold F. McCann, University of Maryland—1940
H. J. Russell McNitt, George Washington University—1925
Sidney Olansky, University of Glasgow, Scotland—1940
John Howell Peacock, Emory University—1934
John Bruce Ross, Johns Hopkins University—1940
John Collis Sherburne, George Washington University—1944
Andrew Leonard Smith, George Washington University—1941
Samuel Ross Taggart, University of Nebraska—1938
Andrew John Welebir, College of Medical Evangelists—1914

Associate Members

Delmer Jencks Brown, College of Medical Evangelists—1940
Adolph Edward Drexel, University of Georgia—1929
Emma Hughes, College of Medical Evangelists—1925

MEETINGS

Wednesday, April 10

The Section on Pediatrics will present the following program: "Influence of the Endocrine Glands on Growth and Development during Childhood and Adolescence," LAWSON WILKINS, M.D., Associate Professor of Pediatrics, Johns Hopkins University School of Medicine.

Wednesday, April 17

The following program will be sponsored by the *Washington Academy of Surgery:*
"Intravenous Fluids with Especial Reference to Proteids," CHARLES STANLEY WHITE, M.D., F.A.C.S., Washington.

Wednesday, April 24

Speakers and subjects to be announced.

News and Personals

The Eastern Section of the American Congress of Physical Medicine will hold its spring session in conjunction with the New York Society of Physical Medicine and the Pennsylvania Academy of Physical Medicine at Walter Reed General Hospital, Saturday, April 13. Registration will begin at 9 a.m. Following an orientation talk by Lt. Colonel Ben Boynton, M.C., U.S.A., there will be conducted tours to acquaint registrants with the facilities of the Physical Medicine Program at Walter Reed.

At the afternoon session, beginning at 2 p.m., the following papers will be presented:

"The Place of Neostigmine in the Therapy of Chronic Arthritis, with Case," Dr. Herman Kabat, Consultant in Neurology and Rehabilitation, District Health Department.

"Problems of Arthritis Treated by Physical Medicine," Major Harry Kessler, Veterans' Administration.

"Causalgia and Its Treatment," Dr. Karl Harpuder, Assistant Clinical Professor of Medicine, Columbia University.

"Rapid Rehabilitation Following Hand Injuries," Dr. Harold Lefkoe, Secretary, Pennsylvania Academy of Physical Medicine.

"Modern Physiological Concepts of Spinal Cord Function and Poliomyelitis," Dr. Ernst Fischer, Professor of Physiology, Baruch Center of Physical Medicine, Medical College of Virginia.

"A Consideration of Certain Physiological and Kinesiological Principles That Are Frequently Neglected in the Application of Therapeutic Exercises," Commander Chas. D. Giauque, U.S.N.R., Coördinator of Physical Training Component of Rehabilitation Program of U. S. Naval Hospitals.

A Postgraduate Course in Diseases of the Chest will be given under the auspices of the Illinois Chapter of the **American College of Chest Physicians** at Michael Reese Hospital, Chicago, during the week April 1–6, 1946. Detailed information may be secured from the Office of the American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Ill.

The College also announces that Dr. Jay Arthur Myers, Minneapolis, Minn., was elected Chairman of the Editorial Board and Editor-in-Chief of *Diseases of the Chest* at a meeting of the Board held at Cincinnati, Ohio, November 11, 1945. He succeeds Dr. Ralph C. Matson, Portland, Oregon, deceased.

CALENDAR OF MEETINGS

February 4	House Committee
February 5	First Lecture, Postgraduate Course in Diagnosis
February 7	Section on Neurology and Psychiatry
February 11	Second Lecture, Postgraduate Course in Diagnosis
February 13	Scientific Meeting of Society
February 14	Interprofessional Conference
February 15	Committee on Service Physicians
February 18	Board of Censors Third Lecture, Postgraduate Course in Diagnosis
February 21	Subcommittee on Venereal Disease
February 25	Executive Board Grievance Committee
February 26	House Committee
February 27	Scientific Meeting of Society

The American Association for the Study of Goiter, which has held no annual meeting since 1941, announces that these meetings will now be resumed, the first to take place June 20–22, at the Drake Hotel, Chicago. The date has been scheduled to make it convenient for those who wish to attend the meetings of the American Medical Association in San Francisco, Calif., on July 1.

The 1947 exhibition of the **American Physicians Art Association,** which will be held at Atlantic City on the occasion of the Centennial Session of the American Medical Association, originally scheduled for the 1946 AMA Session, will also be the occasion of the judging of the "Courage and Devotion Beyond the Call of Duty" art prize contest, when $34,000 in savings bonds will be awarded. The new date will give the physicians an additional year to complete their art projects. Further information may be secured from Dr. Francis H. Redewill, Flood Building, San Francisco, Calif., or from the sponsor, Mead Johnson and Company, Evansville 21, Indiana.

The American Foundation for Tropical Medicine has awarded the **Richard Pearson Strong Palladium Medal** to **Brigadier General George Russell Callender,** Commandant of the Medical Department Professional Service Schools of Washington, D. C. The citation which accompanied the award stated that under General Callender's supervision and guidance, research in the school "contributed directly to the achievement of the lowest sick-rate of any army in the history of war"; also, "his initiative and effort were largely responsible for the creation of the course in tropical medicine and for the development of extensive research activities at the Army Medical School in 1941 before Pearl Harbor. As a result of the typhus vaccine developed in 1942 not a single United States soldier died of epidemic typhus fever."

The medal together with an honorarium of $500, both gifts of the Winthrop Chemical Company, were presented to General Callender, February 7, at the sixth annual meeting of the Foundation at the University Club, New York.

Upon the recommendation of the **Deans' Committee,** 28 part-time senior consultants to the staff of **Mount Alto Veterans' Hospital** have been appointed by Major General Paul R. Hawley, Acting Chief Medical Director of Veterans' Administration. All consultants are specialists, most of them affiliated with the staff of either George Washington or Georgetown University School of Medicine. The fields of medicine included together with the specialists in each field are as follows:

Bacteriology: Dr. Leland Parr
Clinical Laboratories: Dr. Eugene R. Whitmore
Dermatology: Dr. Harry F. Anderson
General Surgery: Drs. Charles Stanley White, Fred R. Sanderson, John H. Lyons and Harry H. Kerr
Gynecology: Dr. John L. Parks
Internal Medicine: Dr. Roy D. Adams
Neurology: Dr. Walter Freeman
Neurosurgery: Drs. James W. Watts and John J. Shugrue
Ophthalmology: Drs. Sterling Bockoven, Ernest Sheppard and Edward J. Cummings
Orthopedics: Drs. Custis Lee Hall and Edward Larkin
Otolaryngology: Drs. Daniel Moffett and Frederick Schreiber
Peripheral Vascular: Dr. Hugh H. Hussey
Plastic Surgery: Dr. William C. Meloy
Psychiatry: Dr. Winfred Overholser
Radiology: Dr. Fred Coe
Syphilology: Dr. William H. Hough
Thoracic Surgery: Dr. Edgar W. Davis
Urology: Drs. Frederick A. Reuter, William P. Herbst and Charles P. Howze

The Coördinating Board of the Washington Metropolitan Health Council met January 31 at the Roger Smith Hotel. Dr. Herbert P. Ramsey was reëlected Chairman, and Howard Strong, Executive Secretary of the Health Advisory Council, Chamber of Commerce of the United States, was reëlected Vice Chairman. Major General George F. Lull, former deputy surgeon general of the Army, who has moved to Chicago, was elected an honorary board member. Four new members were added to the Board, as follows: Mrs. Barbara Hodges of the National Catholic School of Social Science, for one year; Dr. W. L. Schafer, new health officer of Alexandria, for two years; Major General Paul R. Hawley, Acting Chief Medical Director of Veterans' Administration, and Charles A. Robinson, Secretary of the Chesapeake and Potomac Telephone Company, for three years.

Two new members were elected to the Executive Committee of the Coördinating Board, Mrs. Henry Grattan Doyle and Willard C. Smith. Reëlected were Mrs. William Carter Bowles, Miss Gertrude Bowling, Frederick M. Bradley, Edmund D. Campbell, Major General U. S. Grant III, Vice Admiral Ross T. McIntire, Dr. Winfred Overholser, Dr. George C. Ruhland, Dr. Garnet C. Wilkinson, Dr. Ralph C. Williams and Theodore Wiprud.

Examinations for appointments of medical officers in the Regular Corps of the **U. S. Public Health Service** will begin on April 4 at various convenient localities throughout the country. Examinations are for appointments to fill vacancies of Assistant Surgeon (First Lieutenant) and Senior Assistant Surgeon (Captain).

Examinations will be oral and written. The written examination will be held on May 14, 15 and 16 at places convenient to the candidate and the Service. National Board grades may be used for the Assistant Surgeon examination. The oral examination will be held in various cities throughout the United States. April 4 and May 13 are the dates scheduled for the oral examination in Washington, D. C.

Application forms may be obtained by writing to the Surgeon General, U. S. Public Health Service, Washington 25, D. C.

The George Washington University Medical Society held its 20th annual banquet and alumni reunion, February 16, at the Mayflower Hotel, with a record attendance of 556. Major General Leslie R. Groves, Assistant Chief of Engineers, U.S.A., spoke on the timely subject, "Atomic Energy and the Atomic Bomb." General Groves was the officer in charge of the Government's atomic bomb project. A talk on "The Medical Effects of the Atomic Bomb on Buildings, Materials and Humans" was given by Colonel L. Warren, who is chief of the medical section of the Manhattan Engineering District. Several musical selections were furnished by the George Washington University Glee Club.

Dr. Charles Stanley White was presented a scroll containing resolutions on his services to medicine as a surgeon and teacher.

A reception in honor of returning medical officers was held in the Chinese Room preceding the dinner.

The Kober Medical Society, whose regular meetings have been suspended during the war years, held a mid-winter meeting at the Mayflower Hotel, February 18. Dr. Joseph S. Lawrence, Director of the Washington office of the Council on Medical Service and Public Relations of the American Medical Association, discussed voluntary prepayment medical plans as opposed to Federal compulsory plans. Dr. Claude Moore, President of the Society, presided.

Dr. Lewis G. Beardsley, Manager of Mount Alto Veterans' Hospital for the past 13 years, has been appointed Manager of the Veterans' hospital at Newington, Conn. Originally appointed to Mount Alto in 1925, where he established the first diagnostic center in the Veterans' Administration, he served there until 1931, when he was transferred to Newington. He returned to Mount Alto as Manager the following year. Last November he was succeeded by Dr. Charles M. Griffith, former Director of Medical Services for V.A. In the interim Dr. Beardsley has served in the central office as a special medical officer.

Health Officer George C. Ruhland has appointed a new **Advisory Committee on Tuberculosis** to carry on the work in that field which ceased when several members resigned last year. Dr. James G. Townsend, U. S. Public Health Service officer, will serve again as Chairman of the group. New members and the organizations they represent are: Dr. Irving Winik, D. C. Tuberculosis Association; Dr. John W. Trenis, the Medical Society of the District of Columbia; and Dr. Sterling M. Lloyd, Medico-Chirurgical Society, Inc. Members from the previous committee who will serve are Dr. Samuel C. Ingraham, U. S. Public Health Service; Miss Gertrude H. Bowling, Instructive Visiting Nurses' Society; and Dr. Melvin P. Isaminger, representative of the District Health Department.

Brigadier General Malcolm C. Grow became The Air Surgeon of the Army Air Forces, January 1, 1946, replacing **Major General David N. W. Grant,** now retired.

General Grow, a graduate of Jefferson Medical School, began service in the Russian Army (1915–17), then served with the U. S. Army in France and with the occupation troops in Germany during 1918 and 1919. He was Chief of the Air Corps Medical Services from 1934–38 and has served as surgeon of several hospitals. The major positions he has held are Surgeon of the Eighth Air Force, of Strategic Air Forces in Europe, and of Strategic Bombers in the Southwest Pacific. He was responsible for the establishment of the Aero Medical Laboratory, the Eighth Force Personal Equipment Office, the preparation of AAF Air-Sea Rescue Ditching instructions, and the "flak suit" and helmet for air crew. These accomplishments were recognized by the Legion of Merit, Distinguished Service Medal, and the Bronze Medal.

General Grant, an Honorary Member of the Medical Society of the District of Columbia, held the position of Air Surgeon from 1940 to 1945. He is a native of Richmond, Va., and a graduate of the University of Virginia Medical School. He served overseas in World War I, and with the the Army of Occupation in Germany as Commanding Officer of a sanitary train. He has held numerous responsible positions and received many awards.

Brigadier General George C. Beach, Jr., of Topeka, Kansas, assumed the office of Commanding

General of the Army Medical Center, February 9, 1946, succeeding **Major General Shelley U. Marietta,** who has retired from active service.

General Beach graduated from the University Medical College of Kansas City, Mo., in 1911 and entered the Army in November, 1916. He has served in the Panama Canal Zone, the Philippine Islands, as well as within the United States, and was chief surgeon in charge of the Gold Star Pilgrimage to Europe in 1931. His most recent assignment has been the command of the Brooks General Hospital at Fort Sam Houston, Texas. He holds the Distinguished Service Medal and the Legion of Merit.

General Marietta, who has been in active service for 35 years, has been stationed at Walter Reed Hospital since December, 1939. He received the degree of Doctor of Medicine from the College of Physicians and Surgeons, Illinois, in 1909. He served in France in World War I and afterward was stationed in many different parts of the United States. He holds the Distinguished Service Medal and the French Officier d'Academie with silver palms.

The 1946 Conference of State Secretaries and Editors was held at the offices of the American Medical Association, Chicago, February 8 and 9. **Dr. Wallace M. Yater, and Theodore Wiprud,** Editor and Managing Editor of the MEDICAL ANNALS, respectively, were in attendance. **Dr. Joseph S. Lawrence,** Director of the Washington office of the Council on Medical Service and Public Relations of the AMA, took part in the discussion on medical legislation.

Dr. Yater and Mr. Wiprud also attended the **19th Annual Meeting of the National Conference on Medical Service** which was held at the Palmer House, Chicago, February 10.

Upon the recommendation of **Dr. Wallace M. Yater,** Editor of the MEDICAL ANNALS OF THE DISTRICT OF COLUMBIA, the **Executive Board,** at its meeting, January 29, approved the appointment of the following members of the Society to the Editorial Board as Associate Editors: **Dr. James N. Greear, Jr.,** Ophthalmologist; **Dr. Donald Stubbs,** Anesthetist; **Dr. Joseph S. Wall,** Pediatrician; and **Dr. Charles Stanley White,** Surgeon.

The Pan American Medical Association held a dinner meeting, January 24, 1946, in the Pan American Room of the Statler Hotel, which was well attended by members and guests. A resolution was offered and passed in memory of the recently deceased First Vice President, Dr. Guy W. Leadbetter.

Election of officers ensued. Those who will serve are as follows:

Dr. Winfred Overholser, *President;* Dr. A. B. Coulter, *First Vice President;* Dr. Watson W. Eldridge, *Second Vice President;* Dr. Charles H. McEnerney, *Third Vice President;* Dr. Frederick A. Reuter, *Secretary;* Dr. Paul F. Dickens, *Treasurer.*

The President introduced the speaker of the evening, His Excellency The Ambassador of Panama, Dr. J. J. Vallarino, who read a paper on "The Radiologic Observations in Amoebic Colitis" which he illustrated with lantern slides. Several members participated in the discussion which was led by Dr. A. C. Christie.

Plans are being made for joint informal meetings of **Washington and Baltimore physicians engaged in the practice of allergy.** Members of the Medical Society who are interested in the plans are invited to communicate with Dr. Harry S. Bernton, 1925 Eye Street, N.W., Washington 6, D. C.

Dr. John L. Parks, of George Washington University School of Medicine, has announced the appointment of a medical staff of four physicians for the **House of Mercy,** recently reopened, which is an Episcopal home for unmarried mothers in the District. Dr. Parks is trustee and medical consultant of the Home. The physicians appointed are Drs. Walter Willard Boyd, Stafford W. Hawken, J. Earl Kadan and J. Francis Warren.

At the meeting of the **Interprofessional Conference,** February 14, **Theodore Wiprud,** the Society's Secretary, led discussion on the pending national health legislation which has been introduced by Senator Wagner and Representative Dingell.

At a meeting of the Board of Directors of the **Society of Garfield Memorial Hospital,** January 22, **Dr. H. C. Macatee** was reëlected to serve for another three-year term.

Dr. Samuel A. Vest, Associate Professor of Urology at the University of Virginia, addressed the **Washington Urological Society,** February 6, at the Mayflower Hotel. He spoke on "Genitourinary Diseases in Children." More than 300 physicians were present.

Vice Admiral Ross T. McIntire, Surgeon General of the Navy, presented various aspects of the rehabilitation program of the Navy at a meeting of the Washington Society of the Hard of Hearing, February 15, at the Society's clubrooms.

Dr. William P. Herbst, President of the District Social Hygiene Society, discussed the present status of the District's venereal disease situation at a luncheon meeting of the Society, February 13, which was designated Social Hygiene Day. Mr. Alvin Johnston, Chief Counsel for Federal Works Administration, gave the principal address.

Mr. Joe W. Savage, of Charleston, West Virginia, formerly Executive Secretary of the West Virginia Medical Association, has been appointed Executive Director of the National Foundation for Infantile Paralysis. Mr. Savage was recently discharged from the Army Air Force with the rank of Major after having served for three and a half years.

Dr. Charles E. Law has recently been added to the faculty of George Washington University School of Medicine as Instructor in Medicine.

The Moore General Hospital, Swannanoa, North Carolina, has been designated as a specialty center for tuberculosis, pending expansion of Veterans' Administration facilities for the care of tuberculous patients.

Dr. Harry S. Lewis was reëlected President of the Hebrew Home for the Aged at the 32nd annual meeting of the organization, January 20. **Dr. Alex Horwitz** was elected to the Board of Directors for a three-year term.

Prince Georges General Hospital opened an outpatient clinic, February 7, for persons unable to engage a private physician. Dr. W. B. Moyers, Chief of the Medical Staff, will supervise the work. Assisting him will be Dr. Leslie French as medical officer; Dr. Thomas Christensen in pediatrics; Dr. Francis Warren in obstetrics and gynecology; and Dr. Louis Jimal, in surgery.

CORRESPONDENCE

WASHINGTON, D. C., February 13, 1946

MR. THEODORE WIPRUD, SECRETARY
THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA
1718 M STREET, N.W.
WASHINGTON, D. C.

DEAR MR. WIPRUD:

Miss Anne Lamberton, of China, is asking for medical journals (preferably copies of specialty periodicals) to aid in refurnishing Medical Libraries in China.

If you know of anyone who can furnish these, we will be glad to have them brought to the hospital to be forwarded to Miss Lamberton. Thank you.

Sincerely yours,
MARGARET S. BECHTOL, DEACONESS
Acting Superintendent, Episcopal Eye, Ear and Throat Hospital

BOOKS RECEIVED FOR REVIEW

Acknowledgment is made of the following books which have been received for review. After the reviews have been published the books will be placed in the New Book Section in the Medical Society's Library. There they may be examined at leisure but cannot be removed from the building.

Men Without Guns. DE WITT MACKENZIE, War Analyst of the Associated Press. Descriptive captions by MAJOR CLARENCE WORDEN, Medical Department, U. S. Army; foreword by MAJOR GENERAL NORMAN T. KIRK, Surgeon General, U. S. Army. Price, $5.00. Pp. 152, with 177 drawings, including 118 plates in full color by famous contemporary artists. Philadelphia: Blakiston, 1945.

The Care of the Aged (Geriatrics), 5th ed. MALFORD W. THEWLIS, M.D., Attending Specialist, General Medicine, United States Public Health Hospitals, New York City; Attending Physician, South County Hospital, Wakefield, R. I.; Director, Thewlis Clinic; Special Consultant, Rhode Island Department of Public Health. Price, $8.00. Pp. 500, with 65 illustrations. St. Louis: Mosby, 1946.

Hypnoanalysis. Lewis R. Wolberg, M.D., Lecturer in Psychiatry, New York Medical College, with foreword by A. Kardiner, M.D., Assistant Clinical Professor of Psychiatry, Columbia University. Price, $4.00. Pp. 355. New York: Grune & Stratton, 1945.

REPRINTS RECEIVED

The following reprints have recently been received, for which due acknowledgement is made:

"What Doctors Know About Arthritis." W. W. Bauer. The American Mercury, September 1945.

"Labor-Management Relationships in Industrial Health Problems." J. J. Bloomfield. The Journal of the American Medical Association, June 30, 1945.

"Statistical Study of 265 Cases of Heat Disease." Daniel L. Borden, James F. Waddill and George S. Grier III. The Journal of the American Medical Association, August 25, 1945.

"Studies on the Interrelation of Fats, Carbohydrates, and B-Vitamins in Rat Nutrition." R. K. Boutwell, R. P. Geyer, C. A. Elvehjem, and E. B. Hart. Archives of Biochemistry, June 1945.

"Amyotonia Congenita (Oppenheim); Report of Five Cases with Necropsy; Discussion of the Relationship between Amyotonia Congenita, Werdnig-Hoffmann Disease, Neonatal Poliomyelitis and Muscular Dystrophy." William F. Burdick, Dorothy V. Whipple, and Walter Freeman. The American Journal of Diseases of Children, May 1945.

"American Medicine Tomorrow." Mac F. Cahal. Radiology, May 1945.

"Birth Statistics as an Index of Interdependence of Counties with Regard to Medical Services." Antonio Ciocco and Marion E. Altenderfer. Public Health Reports, August 24, 1945.

"Influenza and Pneumonia Excess Mortality at Specific Ages in the Epidemic of 1943–44 with Comparative Data for Preceding Epidemics." Selwyn D. Collins. Public Health Reports, July 20 and 27, 1945.

"Causes of Failure in the Treatment of Squint." Frank D. Costenbader. American Journal of Ophthalmology, October 1945.

"Psychotherapy; Potentialities for Psychotherapy on Navy Hospital Wards." Ralph M. Crowley. Psychiatry: Journal of the Biology and Pathology of Interpersonal Relations, February 1945.

"Max Brodel, 1870–1941, Director of the First Department of Art as Applied to Medicine in the World." Thomas S. Cullen. Bulletin of The Medical Library Association, January 1945.

"Incidence of Poliomyelitis in the United States in 1944." C. C. Dauer. Public Health Reports, June 8, 1945.

"A Study of Nursing School Health Practices and a Recommended Health Program for Student Nurses." Burnet M. Davis, Robert H. Felix, Charlotte Silverman and Marion E. Alterderfer. Public Health Reports, Supplement No. 189, 1945.

"The Comparative Potencies of Several Typhus Vaccines." Richard Donovick and Ralph W. G. Wyckoff. Public Health Reports, June 1, 1945.

"A Comparative Study of Sampling Devices for Air-Borne Micro-Organisms." H. G. duBuy, Alexander Hollaender and Mary D. Lackey. Public Health Reports, Supplement No. 184, 1945.

"The Control of Communicable Diseases; Report of a Committee of the American Public Health Association." Public Health Reports, Reprint No. 1697, revised, 1945.

"Cranioplasty with Tantalum Plate." Dean H. Echols and J. A. Colclough. Surgery, February 1945.

"Brucellosis (Undulant Fever)." Alice C. Evans. Miscellaneous Publication No. 34. Washington: U. S. Government Printing Office, 1945.

"The Toxicity of Molybdenum." Lawrence T. Fairhall, Robert C. Dunn, Norman E. Sharpless and E. A. Pritchard. Public Health Bulletin No. 293. Washington: U. S. Government Printing Office, 1945.

"Executive Order Declaring Public Health Service Commissioned Corps a Military Service." Public Health Reports, July 5, 1945.

"What Doctors Know About Headache." Robert H. Feldt. The American Mercury, November 1945.

"Sickness Absenteeism among Male and Female Industrial Workers during 1944, and among Males during the First and Second Quarters of 1945, with a Note on Absence Duration, 1941–44." W. M. Gafafer. Public Health Reports, September 7, 1945.

"Closure of Defects of the Skull with Tantalum." W. James Gardner. Surgery, Gynecology and Obstetrics, March 1945.

"The Philosophical Background of Compulsory Health Insurance." Lowell S. Goin. California and Western Medicine, May 1945.

"Physical Impairments of Members of Low-income Farm Families—11,490 Persons in 2,477 Farm Security Administration Borrower Families, 1940: III. Impaired Hearing for Speech." Mary Gover and Jesse B. Yaukey. Public Health Reports, April 20, 1945; "IV. Defective Tonsils and Adenoids." Mary Gover and Jesse B. Yaukey. Ibid., June 22, 1945. "V. Defects of the Nasal Septum; and Chronic Respiratory Affections, Exclusive of Diseased Tonsils." Mary Gover and Jesse B. Yaukey. Ibid., September 14, 1945.

"Reconditioning for Civilians." Henry B. Gwynn. The Modern Hospital, September 1945.

"Serial Passage of *Plasmodium gallinaceum* in Chick Embryos." Victor H. Haas, Harry A. Feldman and Frances Moore Ewing. Public Health Reports, May 25, 1945.

"Cultivation of Mumps Virus in the Developing Chick Embryo and Its Application to Studies of Immunity to Mumps in Man." Karl Habel. Public Health Reports, February 23, 1945.

"Seroprophylaxis in Experimental Rabies." Karl Habel. Public Health Reports, May 18, 1945.

"Action Now—for a National Medical Plan; a Plea for an Ethical "Package Plan!" Frank P. Hammond. Industrial Medicine, June 1945.

"Studies of the Acute Diarrheal Diseases; XC. Further Cultural Observations on the Relative Efficacy of Sulfonamides in *Shigella* Infections." Albert V. Hardy. Public Health Reports, September 7, 1945.

"Inoculation of Chick Embryos with Sporozoites of *Plasmodium gallinaceum* by Inducing Mosquitoes to Feed through Shell Membrane." Victor H. Haas and Frances Moore Ewing. Public Health Reports, February 16, 1945.

"The Technique of Tantalum Plating of Skull Defects." Arthur J. Hemberger, Benjamin B. Whitcomb and Barnes Woodhall. Journal of Neurosurgery, 1945, **2**, 21.

"Correlation of the Purity of Penicillin Sodium with Intramuscular Irritation in Man." Robert P. Herwick, Henry Welch, Lawrence E. Putnam and Armand M. Gamboa. The Journal of the American Medical Association, January 13, 1945.

"Dairy Products in the Army Ration." Rohland A. Isker. The Military Surgeon, October 1945.

"The Geographical Distribution of Rocky Mountain Spotted Fever and Nuttall's Cottontail in the Western United States." Wm. L. Jellison. Public Health Reports, August 17, 1945.

"Facts About Asphyxia." Paul W. Kearney. The American Mercury, January 1945.

"New Dosage Forms of Penicillin; Statement Concerning Certifiable Penicillin Products, including Recommended Indications, Dosages and Precautions." Chester S. Keefer, Robert P. Herwick, Walton Van Winkle, Jr. and Lawrence E. Putnam. The Journal of the American Medical Association, August 18, 1945.

"DDT Water Emulsion in Rice Fields as a Method of Controlling Larvae of *Anopheles quadrimaculatus* and Other Mosquitoes." Frederick L. Knowles and Frank W. Fisk. Public Health Reports, August 31, 1945.

"The Effect of Topically Applied Sodium Fluoride on Dental Caries Experience; II. Report of Findings for Second Study Year." John W. Knutson and Wallace D. Armstrong. Public Health Reports, September 14, 1945.

"Influence of Casein and Other Agents on the Production of Renal Lesions in Rats by Sulfadiazine and Acetylsulfadiazine." Arthur Kornberg, K. M. Endicott, F. S. Daft and W. H. Sebrell. Public Health Reports, June 15, 1945.

"The Role of the Specialist in Military Medicine." Lawrence S. Kubie. Surgery, Gynecology and Obstetrics, January 1945.

"Teamwork for Better Health." John LaCerda. Nation's Business, August 1945.

"Isolation of *Pasteurella tularensis* from Sputum; a Report of Successful Isolations from Three Cases without Respiratory Symptoms." Carl L. Larson. Public Health Reports, September 7, 1945.

"The Relative Value of Liquid Media, Glucose Cystine Blood Agar, and Mouse Inoculation in the Titration of *Pasteurella tularensis*." Carl L. Larson. Public Health Reports, July 27, 1945.

"The Susceptibility of the Golden Hamster (*Cricetus auratus*) to Tularemia." Carl L. Larson. Public Health Reports, July 20, 1945.

"Art for the Doctor's Sake." Rose Laughlin. Hygeia, June 1945.

"A Ten-Year Report of The Tumor Registry of The Yale University School of Medicine Based on Total Admissions for Cancer to the New Haven Hospital 1935–1944." Mary C. MacDonald. The Connecticut State Medical Journal, September 1945.

"A New Reaction Time Apparatus and a New Method of Administering the Reaction Time Test." R. B. Malmo and L. R. Crisp. Public Health Reports, August 17, 1945.

"Bone Regeneration Following Osteomyelitis." Laurence H. Mayers. Surgery, March 1945.

"Repair of Cranial Defects with Tantalum." Frank H. Mayfield and Louis A. Levitch. The American Journal of Surgery, February 1945.

"Studies of the Pharmacologic Action and the Pathology of Alphanaphthylthiourea (ANTU): I. Pharmacology," Wm. T. McClosky and M. I. Smith; "II. Pathology," R. D. Lillie. Public Health Reports, September 21, 1945.

"A Two-Cavity Dust Counting Cell." W. E. McCormick. Public Health Reports, May 4, 1945.

"The Male Change of Life." Thomas Hodge McGavack. The American Mercury, December 1945.

"The 1945 Wagner-Murray-Dingell Bill; an Analysis." M. L. Meadors. The Journal of the South Carolina Medical Association, July 1945.

"The Rochester, Minnesota, Child Health Project." Agnes E. Meyer. The Washington Post, April 18, 19, 20, 1945.

On Writing—Observer

(*Continued from page 138*)

writing assignments. They take a lot of his time, of course, and it is real labor, but then there are satisfactions, too. He like others has had many disappointments. Weary of his task, he has often felt that what he has composed is not worth the paper it is written on, and this may be true. It has been your Observer's experience that when his material has been allowed to "cool" more often than not it does not read well. When it does, he is highly elated.

The physician then must want to write and be willing to devote the time necessary to the task if he is going to do it even passably well. It is to be regretted that there are not more who are so inclined for it is undoubtedly true that much valuable material is lost to readers of medical publications due to this fact.

MEDICAL ANNALS

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DISTRICT OF COLUMBIA

VOLUME XV *April, 1946* NUMBER 4

AN APPRAISAL OF STATE-CONTROLLED MEDICINE*

FRANK H. LAHEY, M.D., F.A.C.S.
Boston

OUR approach to state-directed medicine has been most unfortunate. I attended a meeting of the Southern Surgical Association within the past month where there was a rather hot discussion concerning a method of operating. I said it reminded me of what Robert Moses said during a discussion in New York, and it was very apt: "Now we have a good controversial subject, an excellent controversial subject, and we can choose up sides and have a contest." That is about what we have done with state medicine. There have been too many epithets; there has been too much heat and not enough light, and we could go on endlessly, but it is too important a subject for everybody to get hot over. It is too important a subject, not for you and me, nor for what our individual practices will be. That is the wrong approach. It is important in terms of what medicine will be in the future, and that is the point of view from which I should like to approach this subject. I have the greatest respect for the opinion of any advocate of any form of state medicine. We must respect and consider every point of view in this matter.

I would personally like to say that prepaid medicine deserves a place in this country; it should come and must come, for if that is not valuable then life insurance is not. It is distinctly a method of distributing the load which you and I know is heavy. But there are certain things about any form of prepaid medicine which I think must be true if it is to be sound, and if it is not, we get with it not only the good but some of the very bad. We must outstandingly, I believe, have a free choice of doctors. We must outstandingly, I believe, have an upper limit of income to which this plan is applicable. We must have oversight of the agencies which insure in order that your investment in it and my investment in it may not be squandered. In my opinion, it should be voluntary and not compulsory if it is to endure at a proper level of quality. We have had some very honest experiences with the insurance plans, as people who are familiar with them are aware, in which too much has been offered. Note the early experiences of Michigan. The insurer in these early experiences has run into tremendous deficits. It is true that these have been met and taken care of, but those are the things we must avoid. We must not offer more than we can supply either in quantity or quality.

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* From an address before the Society, January 16, 1946.

Why must we have an upper limit of income? In order that there will remain a contract between a sufficient number of people and doctors so that free enterprise, free effort, competition, quality competition, and all the other things that go with what has made this country what it is are retained in order that the quality of medicine will not depreciate. Why must we not have Government-dominated medicine? I have repeatedly said that medicine is at a high level in this country, the highest in the world today. I know from having seen world medicine that as soon as the War is actually over the world will come to America largely for its postgraduate education. As we went to Germany in our time, so will they come to us, because inevitably they must. We have the facilities, we have the men, we have the institutions, and we have the material in quantity. Why must we do the things which can in any way destroy this? And what will destroy it? The abolition of one single factor—quality competition. The thing that has made medicine what it is today is quality competition. It is not price competition; it never has been price competition that has made medicine what it is. It is quality competition in surgery, in medicine, in research, in medical literature, in any part of medicine. The thing I fear, and I assert what I believe to be true, is that under Government dominance, no matter how well intentionally paternalistic it may aim to be, quality competition will depreciate. I have lived in Government during this War, and I have seen very little evidence of quality competition in it. I do not say this critically; I say it because I do not see how it can occur. I would not have traveled this country from one end to the other, lecturing and teaching as I have, to make a reputation in the Government or for the Government. There is for me the reward of personal satisfaction and the reward of accomplishment, and without these we will never retain what we have in medicine today. The great mistake that the people who have not been raised in medicine make—the great mistake that largely the laity make who plan many of these schemes of state-directed medicine, with all the goodness in the world in their souls—is that they think of medicine as a commodity. Medicine is not and never can be a commodity, and if it becomes a commodity you will not like it, I will not like it, and the patient will not like it either, because as a commodity it will not be good. There is an intangible something that lay people laugh at in medicine that makes doctors want to do it, that makes them willing to get up at night. It makes them willing to do charity without vanity. If you make medicine into a commodity, doctors will never want to do those things with the same willingness. If they do them, they will do them because they will have to and not because they want to.

Again we make the mistake, I think, of talking (if I can, I want to avoid contentious terms) about medically underprivileged areas. I say I want to avoid contentious terms, because if ever we need a calm approach to this problem, we need it now. We talk about regions where medicine is not good; it is true, but you could never make it as good as you would like to have it. Why? Because it is not medicine that is not good; it is economics, and you cannot make medicine survive at the desired level in a region which is economically undesirable.

Veterans' care is an example of Government-directed medicine. I say this with regret because, after all, who is responsible for veterans care? We are. It is only recently that we have shouted about it. We have known how bad it was, and we have not done anything about it It has been here under our eyes for years. doubt if there is a surgeon here who has no been rescue-man for a Veterans' Hospital, an has undone and done over things that have mad him know that the medicine and surgery i many of them were not good. It has been excel lent in some of them, and therefore we mus not damn the whole for a relative percentag

But the point is this: If you want a living example of Government-directed medicine, look at the Veterans' Bureau as it was. It was Government-directed medicine at its worst. It is not fair to say that it was Government medicine as it will be under the present national program of veterans' care, but it is an actual completed experiment of what a national program of Government-directed medicine did degenerate to. It is for that reason that I plead that it is so easy to promote a plan and not foresee its possible future consequences.

I should think that this country after its experience with trying to legislate morals and sex and an appetite for alcohol would have learned by now that there are some things that must come by evolution and education and not by compulsion. They cannot come by compulsion. The way to make better medicine in this country is to make better doctors and to teach people what better medicine is. The method that makes things develop along the line, I believe (to be a little religious) the Lord meant them to develop, is evolution. The human mind is not capable of projecting itself sufficiently into the future so that it can visualize the complications that will inevitably arrive and in some unpredictable degree affect what now appear to be such positively good results. A new and greener pasture lies over the hill, and that does not mean that medicine does not need to change. It does in many ways.

We doctors need, I believe, to progress in many ways, and here are some of the ways. We doctors have been a little sanctimonious in medicine. The Irish have a saying that I got from Eddie Cunniffe, who is a typical Irishman. He said that his father once said to him, "From the Saints on earth, may the Saints in Heaven preserve me." The thing we have been a little saintly about is that we believe the way to do good is to do it and say nothing about it. That was all right until we had so much competition and criticism. For example, remember what Dr. Goldwater wrote about hospitals. He said, and it is so true, "Hospitals are constantly advertised by the amount of charity they do. This is true. And hospitals are supported on the basis of the charity they do. But for every dollar of charity they do, some doctor does a dollar's worth, too, that makes it possible, and he never gets a bit of credit for it. It all goes to the hospital." Therefore we ought to, if we can, properly and with due modesty, assert ourselves a little more in terms of what we are doing every day of our lives without publicizing it.

Doctors over the years have been not unlike good wives. Really good wives do not go around telling husbands what good wives they are. I have repeatedly said that they are a great deal like the medicine we have had over the years and have today. To be fully appreciated and realized, a good wife has to die. So conscientious and so self-effacing are most of them that it is only then that they are fully appreciated by their husbands and families.

Now, in a purely facetious way, what would happen if we formed a union and went on strike for a week or more? The thought of such an inconceivable situation in medicine might bring home to some of the irresponsible minds in this country to what an end some of the things that are now happening could come; one might well inquire as to whether or not under Government-directed medicine we could be as sure that it might not happen as we can the way medicine is practiced today.

If I have to choose sides in this contest, I will take the slow and sure one, the one with a long record of accomplishment, and not the quick and uncertain one with no real record of accomplishment.

MYOCARDIAL INFARCTION IN NEGROES

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THERE has been much comment on the rarity of myocardial infarction in Negroes. Repetition of this statement has stimulated us to try to determine the truth of the matter. The questions to be answered were: 1. Does clinically significant coronary artery sclerosis occur as often and with the same severity in Negroes as in Caucasians? 2. What is the relative incidence of myocardial infarction? 3. Are there differences in the clinical manifestations?

Relative Racial Incidence of Coronary Artery Sclerosis

To answer the first question the literature was consulted on the comparative incidence of various forms of heart disease in the white and colored races. Stone and Vanzant[1] in 1927 noted 125 clinical cases of arteriosclerotic heart disease among 501 cases of heart disease in Caucasians and 414 in Negroes over a 5-year period at the John Sealy Hospital, Galveston, Texas; they found this disease 4 times as frequent in whites as in blacks. In 1931 Schwab and Schulze[2] made a study of the new patients seen in the outpatient department of the same hospital in a period of 7½ years. There were 1,172 Negro patients and 488 white patients with clinically diagnosed organic heart disease. In making the diagnosis of arteriosclerotic heart disease reliance was placed mainly on a past history of a probable coronary thrombosis along with electrocardiographic evidence, or on electrocardiographic evidence alone. There were 175 white patients and 160 colored patients, with the incidence in males 3 times as great as that in females. Considering the relative numbers of Negro and white patients, these figures showed arteriosclerotic heart disease to be more than 2½ times as common in Caucasians as in Negroes. In another article[3] in 1932 the same authors stated that arteriosclerotic heart disease was more prevalent in the white race probably because a greater number of Caucasians reach that period of life in which degeneration of the vascular tree commonly occurs.

In 1933 Gager and Dunn[4] collected the statistics on 1,200 cases of heart disease from the various hospitals in Washington, D. C. The diagnosis of coronary artery heart disease was made in 156 white patients and 80 Negro patients, figures indicating the disease to be twice as common in Caucasians as in Negroes. There were half as many female patients as male patients for each race. A pathologic study based on 400 necropsy records was made by Johnston[5] in 1936 for Durham, North Carolina. There were 100 cases of each race and each sex, all of patients over 40 years of age. Marked coronary artery sclerosis was found in 24 white males, 9 Negro males, 10 white females, and 4 Negro females. The author concluded that members of the white race are much more susceptible to coronary artery sclerosis than are Negroes. In 1945 Holoubek[6] reported on a study of 1,045 cases of cardiac deaths in the South (Charity Hospital, New Orleans). She found arteriosclerotic heart disease in 129 white patients (59.4 per cent) and in 88 Negro patients (40.6 per cent). Articles by Davison and Thoroughman[7] in 1928 and by Laws[8] in 1933 are not helpful in answering our first question, since the former included only Negro patients and the latter did not separate coronary artery sclerosis from hypertension but made one group called arteriosclerotic-hypertensive heart disease.

So far as these reports allow us to judge, therefore, coronary artery sclerosis of clinical significance seems to be definitely more common in the white race, although the comparative incidence in the two races varied greatly in the different reports. The unreliability of statistics based on necropsy records performed by different prosectors, however, is notorious, and those based upon clinical diagnosis made by numerous clinicians are even more unsatisfactory. We shall have to await still more extensive studies to get the true answer. So far as the age group 18 to 39 years in males is concerned one of us (W. M. Y.) has found that death was due to coronary artery sclerosis in 21 Negroes among 410 soldiers who died from this cause from 1930 through World War II. The ratio of white to colored troops is roughly 10 to 1, which makes coronary artery sclerosis as a cause of death in this age group twice as common among white males as among colored males.

RELATIVE INCIDENCE OF MYOCARDIAL INFARCTION IN NEGROES

We thought the second question might be answered if we studied the cases diagnosed myocardial infarction at necropsy in the Gallinger Municipal Hospital over a 5-year period, and we selected the years 1940 to 1944 inclusive. During this period in this institution, a hospital of 1,600 beds, there were 16,930 white male patients, 15,749 white female patients, 24,197 colored male patients, and 35,040 colored female patients, or approximately twice as many Negroes as Caucasians. Necropsies numbered 1,904. To our surprise we found that there were 35 white patients and 35 colored patients whose protocols stated that myocardial infarcts were found at necropsy. It had been noted that patients with the clinical diagnosis of myocardial infarction are few in this hospital, but why we do not know. For an institution this size 70 cases of proved myocardial infarction over a 5-year span is a small number.

In studying the protocols we were chagrined to note how sketchy the descriptions of the hearts of these 70 patients were. Consequently, although we place credence in the diagnosis of infarction, we are cautious in accepting the descriptive statements at face value and believe there are many blanks that cannot be filled in. A particularly striking feature, which leads us to question the accuracy of observation, was the relatively large number of infarctions in the right ventricle. However, we can but set down here the statements made. Table 1 gives the location of the infarcts in both races as described.

TABLE 1

Location of Myocardial Infarcts in 70 Cases

	WHITE*	COLORED†
Right Ventricle	3	5
Left Ventricle	27	30
Apex	5	13
Apex and wall	1	0
Apex and septum	0	3
Septum and wall	3	0
Septum	2	2
Posterior wall	8	8
Wall	8	0
Lateral wall	0	2
Multiple	0	1
Entire ventricle	0	1

* Location not recorded in 5 cases.

† Location not recorded in 3 cases.

There were 11 fresh or recent infarcts among the whites and 7 among the blacks, and 17 old or fibrous infarcts among the whites and 20 among the blacks. One infarct in a Negro was described as septic; it was possibly the result of embolization from a bacterial vegetation on the aortic valve. The nature of the infarct was not described in 7 cases for each race.

Gross descriptions of the coronary arteries are given in table 2. Heart weights are recorded in table 3. Since hypertension was definitely present in 10 white patients and 15 colored and aortic valvular lesions in several cases, the large size of this number of hearts is readily explained and appears to rule out the infarction as a cause for hypertrophy.

TABLE 2

Gross Descriptions of the Coronary Arteries in 70 Cases of Myocardial Infarction

	WHITE	COLORED
Occluded	19	19
Left anterior descending	11	9
Right circumflex	8	9
Left circumflex	0	1
Atheromatous	10	8
Sclerotic	10	5
Narrowed, thick, fibrotic	6	5
Tortuous	1	3
Not described	7	6

TABLE 3

Weights of Hearts in 70 Cases of Myocardial Infarction

GRAMS	WHITE*	COLORED†
200–299	3	2
300–399	6	3
400–499	11	10
500–599	4	7
600–699	2	5
700–799	2	1
800–899	2	1
900–1000	1	2

* Not weighed in 4 cases.

† Not weighed in 4 cases.

Mural thrombi were present in the left ventricle in 6 whites and 14 blacks; in the right ventricle in 2 whites and 2 blacks; in the left auricle in 3 blacks; in the right auricle in 1 white and 4 blacks. Extracardiac infarcts were present as follows: renal 10 (3 white, 7 colored), splenic 6 (2 white, 4 colored), mesenteric 3 (all white), cerebral 1 (white), and pulmonary 9 (all colored). There was 1 case of subacute bacterial endocarditis affecting the aortic valve among the white patients and 1 among the colored patients. One case of single coronary artery with thrombosis therein was found among the Caucasians. The left ventricle was ruptured at the site of infarction in 2 cases in each race, cardiac tamponade resulting. A cardiac aneurysm existed in 1 white case. Cardiac dilatation was noted as moderate in 8 cases and marked in 4 cases among the whites, and as moderate in 6 cases and marked in 7 cases among the blacks. Two hearts among the Negroes had aortic stenosis, 1 had mitral valvular disease, and 3 had syphilitic deformity of the aortic valves with aortic aneurysm in 2 of these. There were 2 cases of calcific aortic stenosis among the white patients.

CLINICAL MANIFESTATIONS OF INFARCTION IN THE TWO RACES

The ages of these 70 patients were as given in table 4. It is thus seen that the highest incidence in this series of cases in the Negroes occurred in the fifth decade of life, 10 years earlier than the highest incidence in the Caucasians. There were 3 times as many white males as white females and roughly twice as many colored males as colored females. This series is too small for statistical purposes, but the trends are indicated.

TABLE 4

Age Incidence in 70 Cases of Myocardial Infarction

AGE	WHITE		COLORED	
	Male	Female	Male	Female
30–39	0	0	3	2
40–49	1	0	10	3
50–59	10	2	4	3
60–69	11	3	4	3
70–79	6	2	2	1
Totals	28	7	23	12

The occupations of the two groups were quite similar, being mainly those of domestic workers, common laborers and artisans.

The histories of the previous cardiac status in the 2 groups were as follows:

	White	*Colored*
Congestive failure	15	17
Angina pectoris	3	5
Coronary occlusion or infarction	3	1
Hypertension	4	3
None	3	5
Unknown	7	4

Regarding the occurrence of angina pectoris, more colored patients had it than white in this group. In the series of Stone and Vanzant[1] there were 21 cases among the white patients and none in the colored. Schwab and Schulze[3] found 11 cases of angina pectoris among 4,252 white patients and none among 5,936 Negroes. In the study of Gager and Dunn[4] there were 41 white and 26 colored patients with angina pectoris. In this same series coronary artery thrombosis was diagnosed 23 times in white patients and 5 times in Negroes. Laws[8] stated that substernal pain is not an uncommon complaint in Negroes but that typical angina pectoris is seldom noted.

In our series pain was noted terminally in 18 cases among the white patients and in 15 among the colored. In the white patients it was precordial in 7, substernal in 4, epigastric in 3, in the right side of the chest and substernal in 1, at the costal margin in 1, and in the left upper quadrant in 1. In the colored patients it was substernal in 7, epigastric in 2, in the left side of the chest in 2, in the right shoulder in 1, in the right upper quadrant in 1, in the lower abdomen in 1, and periumbilical in 1. It must be noted, as shown later, that there were conditions other than the coronary artery heart disease that probably accounted for the pain in many of the cases.

Hypertension was present during the last illness in 10 of the white patients and 15 of the colored.

The history was typical of acute coronary artery occlusion in 16 white patients but in only 7 of the colored; atypical but suggestive in 10 white patients and only 6 colored; atypical in 8 white patients and in 19 colored; not obtained in 1 white patient and in 3 colored.

The electrocardiograms showed evidence of anterior myocardial infarction in 2 white patients; posterior myocardial infarction in 1 white patient and 3 colored; "acute infarction" in 1 colored patient; "acute extensive myocardial infarct" in 1 white patient; myocardial damage in 3 white patients and 4 colored; intraventricular block in 3 white patients; left bundle branch block in 1 white patient; and heart block in 2 colored patients (first degree in 2, and 2:1 and 3:1 heart block in 1).

Auricular fibrillation was present in 8 cases among the white patients and 4 among the colored; ectopic beats in 4 of each race; and gallop rhythm in 2 white patients and 1 colored. A murmur was present in 9 white and 19 colored patients (20 apical systolic, 1 aortic systolic, 1 apical diastolic, 2 aortic diastolic, 1 pulmonic systolic, 1 apical and aortic systolic, and 2 apical systolic and aortic diastolic).

Death came suddenly to 26 of the white patients and 14 of the colored. It was gradual in the remainder. Among the white patients coronary artery disease was the primary cause of death in 15, but the diagnosis was made in only 9. Among the colored patients these figures were 11 and 5.

In the cases in which the myocardial infarction was not the primary cause of death there were such primary causes as pulmonary tuberculosis, miliary tuberculosis, carcinoma of the prostate, brain abscess, bronchopneumonia, intestinal obstruction, carcinoma of the breast, chronic nephritis, purulent pericarditis and lung abscess, mesenteric thrombosis, subdural hematoma, cerebral hemorrhage and thrombosis, ruptured appendix and peritonitis, liver abscess, bacterial endocarditis, syphilitic heart disease, and hypertensive heart disease.

Illustrative Cases

Two cases of myocardial infarction are summarized below as examples of this condition in the colored race. The first case was one of multiple infarctions and 2 typical clinical episodes 2 years apart. The second was a case of severe asymptomatic hypertension in which death was due to massive myocardial infarction.

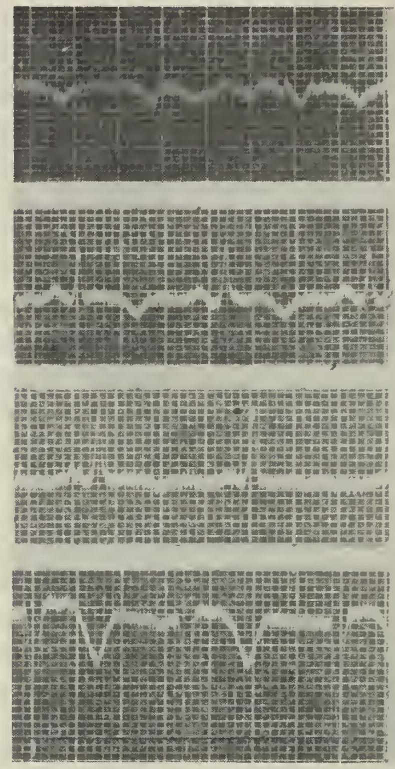

FIG. 1. Case 1. Electrocardiogram made October 30, 1940, Leads I, II, III and IV F, indicating anterior myocardial infarction.

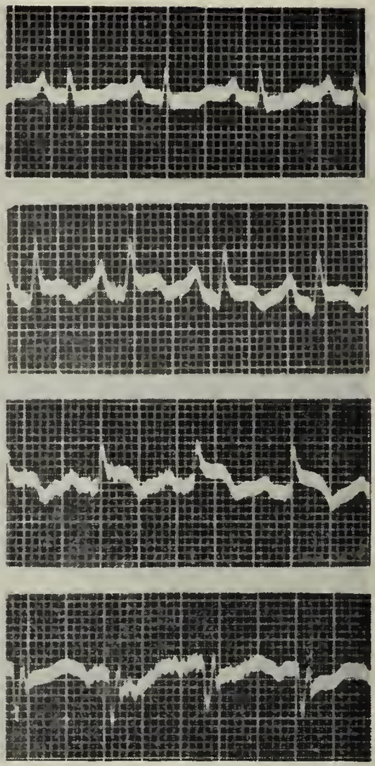

FIG. 2. Case 1. Electrocardiogram made April 22, 1944, Leads I, II, III and IV F, indicating recent posterior myocardial infarction, with absent R_4 resulting from the anterior myocardial infarction of October 1940.

Case 1.—A colored man aged 49 years was a patient in Gallinger Municipal Hospital in December 1940 with all of the typical manifestations of an acute anterior myocardial infarct from which he recovered uneventfully (fig. 1). He did fairly well until the evening of April 19, 1944, when he developed while in bed a sudden, sharp, substernal pain radiating down the left arm. The next day he became nauseated and vomited. The pain on admission was mainly a dull constant epigastric ache with recurrent attacks of substernal pain. The patient was very dyspneic. The pulse was weak and thready. The blood pressure was 75/40. The heart sounds were not audible because the lungs were full of coarse râles and rhonchi. The remainder of the examination was essentially negative and not extensive because of the serious condition of the patient. The electrocardiogram showed the typical findings of a posterior myocardial infarct with absent R_4 as the result of the old anterior infarct (fig. 2). Signs of congestive failure rapidly became more pronounced as shown by the usual clinical signs, elevated venous pressure, and prolonged circulation times. The pulse rate throughout was elevated, averaging 120 per minute. The temperature fluctuated between 98°F. and 102°F. per rectum with a tendency toward normal readings during the last week. The respiratory rate averaged 36 per minute with rapidly recurrent attacks of acute dyspnea and substernal pain. The blood pressure never rose over 120/75. The sedimentation rate was 14 mm. per hour, and the white blood cell count was 10,800 with 72 per cent segmented forms and 7 per cent band forms. The patient grew progressively worse and died after 21 days of illness.

The heart weighed 510 grams. All chambers of the heart were markedly dilated. The anterior descending ramus of the left coronary artery had a patent ostium but the upper one third was completely occluded by an old organized thrombus. The myocardium supplied by this vessel, the apical portion of the left ventricle and an adjacent area of the interventricular septum 5 cm. in diameter, was replaced by well organized scar tissue. The left circumflex artery was thrombosed in its proximal one half. The age of the thrombus was judged to be about 2 months and was moderately well organized. There was not even a pin-point lumen present. There was an infarcted area 2 cm. in diameter in the lateral portion of the left auricle which extended downward into the left ventricle and communicated with a more freshly infarcted area which involved the septal portion of right ventricle for an area of 2 cm. as well as the distal two thirds of the interventricular septum. The latter was judged to be of about 1 month's duration and apparently was the aftermath of thrombosis of the right coronary artery in its proximal one third which was thought also to be of about 1 month's duration. The endocardium over the septal and right ventricular infarcts was covered by a partially hyalinized mural thrombus. The endocardium over the auricular and para-auricular infarcted areas also had a more nearly completely organized, deeply attached thrombus. In none of the mural thrombi overlying the infarcts were there fresh edges. The left and right ventricular walls and the septum as well as the apical portion of the heart were almost completely converted into scar tissue. The valves appeared to be normal.

Case 2.—A 38-year-old Negro was admitted to the hospital on March 31, 1942 with shortness of breath, which had developed gradually over the preceding 2 weeks. During that time he had frequent episodes of paroxysmal nocturnal dyspnea as well as orthopnea. However, he was able to continue at his work as a laborer until 3 days prior to admission. At that time after carrying a heavy weight he experienced a sudden attack of severe substernal pain which "cut off his breath" and lasted for about an hour. He experienced a similar episode of approximately the same duration about an hour later and again the following day. Although the severe pain subsided somewhat, the dyspnea continued until admission. During the 3 days prior to admission he had a slight cough productive of a moderate amount of blood-streaked, yellowish sputum. He did not develop peripheral edema but had several bouts of sweating and fever during the 3 days. There had been no chest pains or anginal attacks prior to the present illness. The past history was essentially negative.

On physical examination the temperature was found to be 102.6°F. rectally; the pulse rate was 150 per minute; the respiratory rate was 42 per minute; and the blood pressure was 80/55. The patient was an obese colored male appearing acutely ill and severely dyspneic. Examination of the eyes revealed evidence of advanced hypertensive changes. There were many coarse basal pulmonary râles. The apex of the heart was in the 6th interspace in the anterior axillary line. The heart sounds were obscured and distant. The rate was extremely rapid and there was a questionable presystolic gallop; the rhythm was regular, and no murmurs were audible. The remainder of the examination was essentially negative. Laboratory studies revealed the urinalysis to be normal; a moderate and persistent leukocytosis; and the blood urea nitrogen on admission to be 94 mg. per cent and 4 days later 30 mg. per cent. The venous pressure was 260 mm. of saline and rose to 275 on right upper quadrant pressure. The arm-to-tongue circulation time was 30 seconds.

The patient was moderately rapidly digitalized but showed evidence of very slight improvement, the temperature and the pulse rate remaining elevated throughout, and the blood pressure rising only to 105/80. Seventeen hours before death he became very weak, with increased dyspnea and cold, clammy skin. He died on April 6, 1942.

The heart weighed 1,000 grams, and its chambers were markedly dilated. On section through the myocardium almost the entire left ventricle was found to be infarcted, only a small amount of fairly normal myocardial tissue remaining. The pathologic lesion consisted of irregular, yellowish-grey, well demarcated areas extending everywhere in the left ventricle and interventricular septum. The apical portion was slightly thinner than normal, and a recent mural thrombus was attached to the endocardium. All of the coronary arteries were markedly sclerotic. The left anterior descending coronary artery was completely occluded about one half the way down by atheromatous deposits. There was no evidence of syphilis, and the valves appeared normal. There were some easily broken adhesions between the pericardium and the epicardium. The lungs revealed acute pulmonary edema with congestion. There was chronic passive congestion of the liver and cloudy swelling of the kidneys.

CONCLUSIONS

Clinically significant coronary artery sclerosis is probably between 2 and 3 times more common in white people than in Negroes. Myocardial infarction is probably about twice as common in Caucasians. Thus coronary arteriosclerotic heart disease and myocardial infarction are far from rare in the black race. There do not appear to be important differences in either the pathologic features or the clinical manifestations between the two races, although the general impression is that the disease is more often less obvious clinically in Negroes. The cause for the difference in the racial incidence of this disease cannot be positively stated, but the differences in temperament and mode of living and the fact that more white people live longer may be factors. However, it appears that the difference in the incidence is about the same for both the younger and older age groups. In the 70 cases of myocardial infarction studied, in which there were 35 white and 35 colored patients, the trend was for the colored patients to die a decade earlier. A similar difference exists, even more certainly, as regards hypertension.

(*Continued on page 198*)

CHILDREN IN WARTIME

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DURING the period of the War the American public finally became more aware of, and in many cases greatly alarmed about, the problem of juvenile delinquency, since it was increasingly and widely publicized by the press of the Nation. In any analysis of the problem it is important to remember that juvenile delinquency existed long before it came to the attention of the press and long before this Nation entered the War. It is also important to realize that the press, in general, tends to exaggerate the more lurid details of juvenile crime and ignore the fundamental bases for this form of antisocial behavior. For that reason the adult citizens of our population, shocked and horrified, have tended, often, to condemn and combat juvenile delinquency on the basis of morality rather than from a comprehensive understanding of the causes that rest beneath it.

Strong measures to repress delinquent behavior, to judge it, to shame the child and make him feel guilty without an attempt to solve the difficulties that are disturbing him result most often in open defiance, increased delinquent behavior, or in withdrawal and secrecy. Thus the actual causes are merely agitated when they should be discovered, understood, and resolved.

In wartime, as in peacetime, the delinquent behavior of children is often a sign of certain unsatisfied needs, usually emotional ones. In other cases it is directly or indirectly due to physical causes. Wartime needs of children are identical with peacetime needs. It does not matter whether we are in an era of peace or under the stress of war; when these needs are neglected, problems arise.

When a child expresses its needs in the form of antisocial behavior, the term "juvenile delinquency" is used. But juvenile delinquency represents only a small part of the problems encountered in child guidance work. Many more children demonstrate disturbances of behavior that are not antisocial and result in distress only to the child involved and to those in the immediate environment.

Parents are usually cognizant of the physical needs of their children, such as nourishment, clothing, shelter, protection and medical care. Unfortunately, parents, unlike animals, are not properly guided by their instincts and are too often oblivious to the basic emotional needs of their children. If the physical needs of the child are met, the body develops properly. In a similar manner, when the emotional needs are met, the attitudes develop properly.

The first and always most basic emotional need of a child is for security. To promote in a child the feeling of being secure, the early environment must hold to a minimum the conditions or situations that breed fear. Discord in the family, illness, frequent changes of address, overdramatized presentation to the child of financial or other family problems, absence of members of the family—all of these and many others contribute to early feelings of insecurity. Children need the knowledge that they are loved, that they have an assured place in the family and community life, and that they have a chance to develop and use in suitable ways their intelligence, judgment and initiative. This fundamental knowledge cannot be conveyed to them through a home environment that seems to tremble constantly on the verge of an emergency, a crisis or a disaster. It cannot be conveyed to them by parents who are themselves insecure. Only fairly secure parents can have secure children. Perception of attitude is one of the most powerful forces in our culture. Adults more or less behave conventionally because of group pressures. This is perception of attitude multiplied many times. But adults are often unaware of how quickly children perceive and repeat the attitudes of the older members in their environment.

It has long been recognized that the most impressionable years of the individual are from about 6 months to 6 years. During this time the behavior pattern of the individual is developed. The ability of the individual to direct behavior into satisfying and acceptable channels is dependent on a balance between gratifications and renunciations. The first gratifications and restrictions are controlled by the parents, especially the mother. The child can accept conformity, which requires some restrictions, when there is assurance of being given parental love as compensation.

In addition to an environment offering a maximum of security and freedom from fears, children need the opportunity for developing maturity. However, when a kindly, indulgent, oversolicitous, or dominating parent (usually the mother) continues to offer unnecessary assistance to the developing child, this initiates and perpetuates a pattern of behavior that makes for immaturity. Later this continued need for assistance or drive from the outside results in abnormal dependency, hostility, and lack of ability to assume responsibility. Immature individuals function emotionally when they should function rationally. Eventually this results in some form of neurotic behavior that gives rise to personality disorders or many physical complaints which are termed "nervous," and are tensions engendered by the emotions. This type of behavior is perpetuated for several generations, often in the form of alcoholism or criminality. It is usually not the result of heredity but of an uncomprehending and faulty environment. Only intelligence and physical characteristics can be inherited. Attitudes result from life experiences.

Not all of the problems among children are due to unrecognized emotional needs. Various physical conditions also contribute to the problems of childhood. Many children disparagingly called "lazy" are frequently actually ill. These children may be suffering from an unrecognized cardiac, kidney or respiratory disorder. There are at least 1,500,000 children suffering from impairment of hearing, and over twice as many suffering from some degree of visual impairment. Frequently a child's lack of interest in school, or even apparent disobedience, is due to such defects.

Many children suffer from some form of impairment of the nervous system. This portion of the body is the last to develop and does not mature until the child is about 3 years old. For this reason, this system is especially vulnerable to any form of insult early in life. Lack of oxygen, as in pneumonia or whooping cough, nutritional deficiencies, or toxemia from disease processes may reflect in the development of the brain and affect the behavior of the individual.

Intelligence is a basic quality that is definitely inherited, but it may be affected by the early environment or illness. Abstract intelligence or ability to handle ideas, and manual intelligence or ability to use the hands, vary considerably in various individuals. About 30 per cent of retarded children who are actually lacking in intelligence inherit this liability. The others acquire it during or after birth through illness or injury. Often in an attempt to compensate for some physical or mental defect a child may assume an abnormal form of behavior. When these conditions are recognized early enough, the individual's potentialities can be more properly developed. About 2 per cent of serious behavior disorders in children result eventually in an insanity. Some of these may be affected by the hereditary pattern, but most result from improper early environment.

Behavior problems in childhood result in neurotic adults. Selective Service reveals that 30 per cent of the rejections and at least 35 per cent of the discharges are for nervous or mental reasons.

Even before the war emergency about 300,000 children appeared before juvenile courts annually. (This figure, as indicated earlier, represented only a small percentage of unhappy problem-children.) The youngsters whose antisocial behavior brought them afoul of the law in the past generation also contributed to the more than a million people in the United States incarcerated in various types of institutions at this time. Unless the significance of the relationship of early childhood problems to maladjustments in adolescence which lead to adult criminals can be appreciated, the next generation will be even more handicapped by maladjusted individuals.

It becomes clear, then, that the real responsibility for lowering the percentage of neurotics, delinquents, and criminals in our society rests with those who are responsible for the children in our society.

Although conditions for children in the United States remain highly favorable in comparison with those in countries suffering the direct effects of the War, many problems of child welfare are intensified. Many suffered the effects of the lowered incomes of fathers and brothers in the services. There are obvious shortages of medical services and trained teachers. There were 5,000,000 to 6,000,000 working mothers with children under 14 years of age. There is some lack of adequate recreational facilities. All of these defects contribute to increased insecurity in the home and the community. Since our entry in the war effort, there already has been an increase of 11 per cent of delinquency in boys and over 38 per cent in girls, although boys usually outnumber girls over 4 to 1.

Children were quick to feel the restlessness and excitement characteristic of the war effort. They will be affected similarly by the transition from war to peace. New problems that demand satisfactory solution will come up. They are increasingly confronted with the loss or absence of loved ones. They will also be confronted with their return and with the necessity of sharing the position they have grown accustomed to in the love of the mother and other members of the family. Furthermore, the returned individual may suffer from some physical or mental disorder. All these factors may contribute to the insecurity of the child involved.

As more and more normal men were inducted into the armed services, and the abnormal types were recognized, rejected and returned to civil life, they represented a proportionately large percentage of the civil population. This figure is increased by the nervous and mental discharges from the armed services. These should not be permitted to affect our young ones adversely. Many men returning from the services suffer from unresolved hostility, engendered during the period of indoctrination in the form of hate for the enemy. This is the cause of our present wave of suicides, homicides and other forms of aggressive behavior.

It is obvious that the children of the countries involved in the War are affected by its impact, as a result of the effect on their environment and living conditions. The first World War left the Germans and their children full of hostility, which was perpetuated and aggravated by Nazi doctrines. This fact made them predisposed individuals, ripe for the present conflict. The present generation will be left with the same attitude, and any efforts directed toward punishing them will only increase their insecurity. Added to this is the fear and hate inculcated in the impressionable minds of the children in the invaded countries. Revenge will not relieve their insecurity.

In America certain steps have been and are being taken to meet the challenge of our postwar conditions. Some families have increased incomes, and there are better homes for some war workers. Efforts are being made to improve food distribution and develop school lunch programs. Hospitals and recreation centers

(*Continued on page 198*)

GASTROSCOPY IN THE DIFFERENTIAL DIAGNOSIS OF GASTRIC ULCER*

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FOR many years the medical profession has been interested in methods by which the gastric mucosa could be inspected with safety and nonsurgical means. In 1932 Schindler[1] perfected a flexible gastroscope which fulfilled these criteria, and gastroscopy became revitalized and universally acceptable as a diagnostic aid. During the past 10 years I have gastroscoped 291 patients and of this number it was an office procedure in 238; the remaining 53 were examined in the clinics of Washington hospitals. In every instance extensive studies had been carried out before gastroscopy in order that the gastroscopic pictures could be adequately correlated with the clinical findings. In the majority of cases the X-ray examinations were negative but the symptoms suggested some intragastric disease, while in others there was positive roentgenographic evidence of organic disease within the stomach without substantial clinical evidence of its presence. Gastroscopy was of major value in 30 per cent of the cases, and of secondary value in 50 per cent. It was of no value in 20 per cent. In very few patients was gastroscopy undertaken as a routine study, and this is fortunate since special studies should be undertaken for specific indications.

The indications for gastroscopy are numerous and steadily increasing. This is easily understood when one considers the many cases with vague, undifferentiated gastric complaints in which the diagnosis can only be established gastroscopically. Brown[2] has recently stated that any patient of middle age, with unexplained gastrointestinal symptoms should have the benefit of gastroscopy. Bockus[3] states that if an ulcer is well visualized roentgenographically and disappears promptly after the institution of therapy, gastroscopic examination is not essential. If, however, the ulcer is not healing satisfactorily or has actually increased in size, the endoscopic procedure is particularly valuable in determining the nature of a crater.

In addition to being an important aid in differential diagnosis, gastroscopy is advantageous in observing directly all types of chronic gastritis, in following the progress of gastric ulcers, in determining the operability of malignant lesions, in examining the stomach postoperatively, in locating the site of bleeding in gastric hemorrhage, in deciding whether a tumor or ulcer is benign or malignant, and in studying the effect of treatment of the various gastric conditions.

In any type of instrumentation one must be aware of the contraindications. Stenosis or obstruction of the esophagus, either organic or spasmotic, is the most important contraindication to gastroscopy. Other contraindications are aneurysm, varices of the esophagus, severe kyphoscoliosis, cardiac insufficiency, dyspnea, fever, and high blood pressure. In some of the enumerated conditions gastroscopy has been performed, but it should be done with extreme caution and with an understanding of the hazards involved.

In general it might be said that instrumentation and orientation are relatively easy in the performance of gastroscopy. Orientation or the ability to identify anatomic landmarks involves considerable study but can be accomplished with diligent application. However, all parts of the stomach are not available for inspection. "Gastroscopic blind-spots," or areas not visualized, are the lesser curvature of the antrum and a small area in the fundic end of the stomach.

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* Read before the Postgraduate Assembly of the George Washington University School of Medicine, February 15, 1946.

Interpretation is one of the most difficult phases of gastroscopy. To acquire the ability to differentiate the normal from the pathologic mucosa involves many factors. The normal mucosa is orange-red; the folds are heaviest on the posterior wall, and delicate on the anterior wall. The antrum is devoid of folds, but peristalsis is clearly observed in this area, and alterations in the circular caudad progress of the waves may have pathologic significance.

True gastric ulcer can usually be seen well through the gastroscope. However, when the ulcer occurs on the lesser curvature of the antrum it is hidden from view by the angulus. The picture of the ulcer is striking. The edge is sharp, with an abrupt transition between the ulcer and the normal mucosa. The ulcer may be round or oval, and the base is brilliant yellowish white or yellow. Occasionally an ulcer is seen that is bleeding or oozing, and then the base may be red. One case observed[4] had an organized clot filling the crater. The question may be raised as to the danger of gastroscoping patients who have recently had a hemorrhage. The answer is based upon the experience of hundreds of gastroscopic examinations which have been performed under these circumstances by experienced gastroscopists without any complications. It has been proven that inflation of the stomach with a small amount of air will not cause bleeding. Movement or peristalsis in the body of the stomach is rarely observed during the examination. It is often desirable and valuable to make a gastroscopic examination after hemorrhage, since the condition found may be ulcer, soft polyp, hypertrophic gastritis or other conditions in which the true nature and the site of the bleeding are important to know. Subsequent treatment may depend a great deal upon this information.

In contrast to benign gastric ulcer, carcinomatous ulcers of the stomach have certain characteristics, which when observed gastroscopically are of great aid in the differential diagnosis. The floor of the malignant ulcer is nodular or irregular, dirty, and purple, brown, or dead white. One edge is usually limited, but the other edge shows a gradual transition of the lesion from the base to the surrounding mucosa. The edge is irregular, rolled or stiff. The diffusely infiltrating lesions are seen in varying degrees of shape, size and color, and often seem to be elevated on a mound. Another sign recently described by Taylor[5] is the presence of a fine adherent froth due to a fermentative process in the base of a malignant ulcer, not seen in benign lesions. This must be distinguished from individually visible bubbles. Schindler[6] is of the opinion that the gastroscopic differentiation between benign and malignant ulcer is more accurate than direct examination of resected or autopsy specimens. This is due to the fact that the blood supply makes the coloring very characteristic whereas in dead tissue this is less obvious.

Other important conditions which must be considered in the differential diagnosis from gastric ulcer are polyps and gastritis. I have previously reported in a series of 200 gastroscopies the gastroscopic aspects of 14 cases of chronic superficial gastritis[7] in which the X-ray diagnosis was in error in each of the 14 cases. The report was not meant to be critical of X-ray errors, because both methods of study are complementary. X-ray examinations of the stomach should and will probably always be one of the most valuable methods of determining the presence and character of lesions in the stomach. There is only a certain small percentage of error, but now and then when the roentgenographic examination may be misleading a gastroscopic study may give us the evidence that is needed to make a correct diagnosis. Every one of the 14 patients had a careful X-ray examination of the stomach. The diagnosis was as follows: in 4 cases, gastric carcinoma; in 1 case, polyp; and in 9 cases the report was negative. The clinical diagnosis was peptic ulcer in 3 cases, possible malignant neoplasm in 3 cases, and functional derangement of digestion in 8 cases. All of these patients were gastroscoped, and in each instance no malignant lesion, polyp or ulcer was observed, but there was unmistakable evidence of chronic superficial gastritis. Subsequent clinical and roentgenologic observations revealed no evidence of ulcer, polyp or malignant neoplasm. It would appear then from these few cases that the clinical syndrome of chronic superficial gastritis (if such a syndrome exists, and this is controversial) may simulate serious gastric disease.

Although a positive gastroscopic report has great value, it is important to remember that negative gastroscopic findings do not necessarily rule out intragastric disease. A number of difficulties may be encountered which can obscure the location or accurate identification of a lesion. Besides the "blind-spots," the factors of hypersecretion, illumination, air inflation, movement and others must be properly evaluated in the final interpretation.

Duodenal ulcer cannot be examined by means of the gastroscope, but the accompanying gastritis which pathologists say is always present should be studied. Tumen and Lieberthal[8] gastroscoped 50 patients with duodenal ulcer. Thirty-three were found to have chronic gastritis which did not regularly influence the clinical course of the disease.

Bockus[9] has clearly summed up the problem by stating that the use of both roentgenoscopy and gastroscopy will render the likelihood of missing a peptic ulcer within the stomach rather remote, that the two methods are complementary, and that both should be employed in cases presenting diagnostic difficulty.

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President's Page

VETERANS' PROBLEMS

I understand about three fourths of our members who were with the armed forces are now home. We have tried to make them welcome and to do all we can to help them get back into civilian practice again.

The average veteran does not expect much fuss made over him, but I think he feels some consideration or credit is due him for the two to five years spent with the armed forces. He rightly feels that he should if possible have his old office back, or at least have a chance to secure suitable space and open a new office. I can assure these members that the Committee for Service Physicians and Mr. Wiprud have done everything possible to solve this problem, and I understand it is less of a problem now than it was a month or two ago. As I go about and see houses and apartments being remodeled, I very much hope it is for offices for returning veteran physicians. Many of our members are sharing their offices during this emergency, and although it may work a hardship both ways it surely is an expression of good will.

Another problem is transportation, but the automobile dealers have been most coöperative, and many men have already gotten new cars. The refresher courses that have been made available have been quite satisfactory and well attended. I understand that there has been some unhappiness over hospital privileges and appointments, and I sincerely hope this will be corrected soon.

One returning veteran told me how eager he had been to effect a separation from the Army, yet when it materialized he suddenly felt a queer sense of insecurity. He had not liked the regimentation, yet there was a sureness about his position, respect for his rank, comfortable quarters, the ability to have any laboratory or diagnostic procedures carried out without question, the joy of working in a group, and the security of having his check come in each month with comfortable regularity. When he came out into the bright light of civilian life he blinked a bit and it suddenly dawned on him how difficult it was going to be. He said, "I realized I was going to have to sell myself to the public all over again." Knowing him as I do I know he will have no difficulty doing that, for he is well trained and has a most pleasing personality, but it was a slant on the returning veteran that was new to me, although quite understandable.

It does not seem to me that many home-front doctors would fail to make every effort to get patients to return to the doctors who had treated them before going into the service. Some few patients, and I think very few, might want to continue with the doctor who looked after them during the war years, but I feel sure there are not many doctors who wouldn't insist on such patients returning to their regular physicians.

In conclusion, I do feel that our Society has done an unusually good job of keeping in touch with those in the service during the War, and I am sure the majority of us have tried in every way we can to make the returning veterans feel that we want to do everything in our power to help them get started again in civilian practice.

Wm. Earl Clark

Editorials

U. S. NAVAL MEDICAL CENTER ON GUAM*

On March 15 Secretary of the Navy Forrestal signed an order establishing the U. S. Naval Medical Center on Guam, in the Marianas. This act, performed without any fanfare, nevertheless was one whose importance will be appreciated before very long.

The newly created Naval Medical Center, comprising several integrated units, is intended to fulfill the dual mission of serving naval personnel and the inhabitants of islands in the Pacific Ocean under naval military government. In the pursuit of these two general objectives, however remote they may seem from the aims of civilian medicine, there will come, I am confident, an appreciable accretion to knowledge in the fields of clinical medicine, medical research and medical education. That this enterprise will be the largest and most ambitious of its kind ever set up outside the country by the United States is of no importance in itself. The significance lies rather in the Center's potentialities on a world-wide scale for the gathering and diffusion of knowledge, particularly on tropical diseases.

The U. S. Naval Medical Center on Guam is to be composed of a Naval Hospital for the care of service personnel; the U. S. Naval Institute of Tropical Medicine, successor to Naval Medical Research Unit No. 2; the Guam Memorial Hospital, formerly known as Military Government Hospital No. 203; the School of Medical Practitioners and a nursing school attached to the Guam Memorial Hospital. The Naval Medical Center will be under the military command and coördinated control of naval military government authorities. Administrative management and technical control will be the responsibility of the Bureau of Medicine and Surgery, Navy Department.

With the activities of the various commands carefully integrated, much in the manner of the National Naval Medical Center at Bethesda, Maryland, a far-flung program will be inaugurated for medical care of naval personnel and islanders, prevention and control of epidemics, naval medical research and instruction of insular inhabitants, drawn from the entire Central Pacific area, in medicine and nursing. Health protection, medical and hospital care of some 100,000 natives, scattered over the vast reaches of the Central and Western Pacific are the responsibilities of the U. S. Navy. For many years, albeit on a smaller scale, the Navy has had the job of looking after the health of island inhabitants and so the task at hand is more expanded than new. It will be more in the line of pioneering to operate a large Institute of Tropical Medicine, although a good trail was blazed by Naval Medical Research Unit No. 2 during the last couple of years.

Already the Naval Medical Center, Guam, is a going concern, with all commands in operation except the Institute of Tropical Medicine, which is under organization. It is confidently hoped that close liaison will be established between the Institute and the mainland's institutions of postgraduate learning, permitting the interchange of instructors and students. In line with this policy, Medical Corps Reserves will be available to serve as lecturers and advisors, giving the Navy the peacetime benefit of their knowledge and experience with the reciprocal advantage of keeping up with professional developments which elsewhere could be learned only second or third hand.

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* This is the third in a series of guest editorials by distinguished physicians and laymen. Others to follow will deal with the scientific, social and economic aspects of medicine.

VICE ADMIRAL ROSS T. MCINTIRE
Surgeon General of the United States Navy

SPECIALTY BOARDS

For some years the specialty boards have been operating efficiently with little publicity. Suddenly they have been projected into the limelight because of the widespread demands of the returning veterans who wish to prepare for examination by the boards. What is the explanation? The medical profession has at long last realized that the boards are rendering a great service in raising medical standards. The men who compose the boards have been carefully chosen, and it can be said without qualification that they have conducted the examinations without discrimination or partiality, and with unquestioned fairness. It is possible that certain few candidates have been passed whose qualifications may not be adequate, but time rectifies such apparent errors. On the whole, the conduct of the boards deserves only the highest praise.

That diplomates have been outstanding in their respective specialties is attested by the fact that a certificate from a specialty board is recognized as something to be coveted. So outstanding has been the rating of the successful candidates that one of the requisites for many desirable hospital appointments is that the appointee must be a diplomate of a specialty group. The discharged veterans have been keen to realize the prestige of a certificate from a board, and there has been almost a stampede to attain residencies and assistantships which would qualify them for board examinations. To find a sufficient number of such opportunities has been a serious problem and one that remains unsolved, but one that should not be by-passed or ignored. Those engaged in medical education should redouble their efforts to provide facilities for those men who earnestly strive to qualify themselves. Hospitals, whenever possible, should take stock and reorganize their intern teaching program to qualify it for approval for residencies. Many hospital managements have been apathetic to this growing demand and need stimulation.

The public has not grasped the significance of the classification that the boards are gradually creating, but this information will spread through the press, and we can rest assured that it will be a matter of concern to the patient if his doctor is not a specialist in the real sense. Say what we may, the day of the family doctor is about over except in the sparsely settled communities. Even in small towns and villages we find well qualified specialists. Transportation by car, rail, or plane has almost completely annihilated the medical isolationist, and we look for, in the not too distant future, the time when every community can afford the services of a specialist, as we understand the word. We may regret that the profession is so highly specialized, but that is not an unhealthy trend. The danger lies in accepting a low and loose standard. This is a matter which cannot be regulated or prescribed by legislation at present, but is an obligation to the public that must be discharged solely by the physicians themselves. We have the machinery and the authority to set up such standards and this privilege should not be delegated to any lay body. We should not permit any regulation or standardization of the art and practice of medicine which we can accomplish ourselves to be assumed by others.

The specialty boards have performed a service to the public and the profession for which they have received little appreciation or compensation, and to their everlasting credit it may be said that they have asked for neither.

C. S. W.

STUDY OF CHILD HEALTH SERVICES

Postwar planning for child care has received much attention during recent years from many organized groups and individuals throughout the country culminating in legislation now before Congress. The American Academy of Pediatrics, realizing that the responsibility for such planning rests primarily in the hands of physicians themselves, has launched the Study of Child Health Services in order first to gather necessary facts from which well-founded plans can be evolved, and second to determine the extent and quality of services now available. Thus the physicians, unquestionably the ones who know what constitutes good care and who for the most part provide that care, have accepted the challenge to develop constructive plans for medical service to children.

One of the fundamental purposes of the present study is to stimulate local groups to discover for themselves the needs of their own communities and the facilities to meet those needs. Essentially, this means the collection on a vast scale of adequate and reliable data. Although the members of the Academy are committed to carry out the task, the success of this tremendous undertaking is the responsibility of individual physicians everywhere.

To obtain a complete picture of the existing child health facilities, data will be collected by means of questionnaires (schedules) on every important aspect of pediatric and medical service. Four major categories will be studied: first, Hospital Facilities; second, Community Health Services, official and voluntary; third, Distribution, Qualification, and Activities of Professional Personnel; and fourth, Pediatric Education.

The administration and conduct of the Study in each state will be under the direction of the Academy State Chairman, who, with the help of one or more fulltime Executive Secretaries, will organize the program and correlate all the many activities involved.

It is fully recognized that all doctors are exceptionally busy at this time and for that reason procedures for obtaining the necessary information have been simplified as much as possible. Every effort has been made to utilize available local sources, but certain essential data can be obtained only through the active participation of individual physicians. Specifically, the pediatrician will be asked to fill out a questionnaire dealing with his own training and practice; to supervise the completion of a questionnaire for one or more hospitals in his community; to send out prepared letters to designated practicing physicians informing them of the Study and requesting their coöperation in obtaining information on their pediatric practice; and to assist the Executive Secretary in his state in discussing the program with local, professional and voluntary groups and health officers. Physicians in private practice will be asked to complete a short one-page questionnaire mentioned above concerning their pediatric practice.

This Study is important and unique. It is an opportunity for physicians not only to investigate their own affairs but also to collect factual data as a logical basis for sound medical care programs in the future. Unless the physicians undertake this task others less well qualified will, as indicated already by the action of the federal legislators.

Edgar P. Copeland, M.D.
State Chairman for the District of Columbia, American Academy of Pediatrics

OPTOMETRISTS SEEK TO BROADEN PRIVILEGES

The practice of optometry in the District of Columbia has been governed by an Act approved by the Senate and House of Representatives on May 28, 1924. Section 1 of this Act defines optometry as follows:

"That the practice of optometry is defined to be the application of optical principles through technical methods and devices, in the examination of the human eye for the purpose of determining visual defects and the adaptation of lenses for the aid and relief thereof."

On March 29, 1938, a bill was introduced into the House of Representatives to replace the one enacted in 1924. Section 1 of this bill reads:

"That the practice of optometry is hereby declared to be a profession, and is defined as the science and art devoted to the examination of the eyes, the analysis of the ocular functions, and the employment of preventive or corrective optometric methods and agents for the relief of visual and ocular anomalies."

This bill was defeated.

On October 19, 1945, another bill was introduced in the House of Representatives to regulate the practice of optometry in the District of Columbia. The first section in this bill reads:

"That optometry is hereby declared to be a learned profession, and, for the purposes of this Act, the practice thereof is defined as the science and art devoted to the examination of the eyes, the analysis of the ocular functions, and the employment of lenses, prisms, ocular exercises, visual training, orthoptics, preventive or corrective optometric methods, and agents for the relief of visual and ocular anomalies."

In Section 15 of this proposed bill there is a phrase which, if it became a law, could be interpreted in such a manner that any physician prescribing glasses or orthoptic training would be subject to this Act and thus could be required to have a permit from the Board of Optometry in order to practice his specialty. This, and the first section of this bill constitute the most significant changes in the bills. The language here employed would apparently permit those practicing optometry to greatly extend their method of treatment. One questions the justification or wisdom of such authorization.

That it obviously is the intent of the bill to so broaden the license of the optometrist to practice, appears from the fact that the new optometry bill deletes from Section 19 of the present bill that portion which distinctly prohibits the optometrist from entering upon the province of medical practice or hold himself out to be other than an optometrist.

The bill now under discussion has been studied by representatives of the Medical Society of the District of Columbia, the Washington Ophthalmological Society, and the District of Columbia Society for the Prevention of Blindness. All of them agree that the practice of optometry should be restricted to the measurement and correction of refractive and muscular errors of the eye. They propose the following to be substituted for Section 1 of the new bill:

"That the practice of optometry be defined as the measurement and correction of refractive and muscular errors of the eye by any method not including the use of drugs and not including surgical procedures such as cutting or actual manipulation of the eyeball, but including the use of optical appliances for diagnosis or correction of such refractive and muscular errors."

The committee also recommended that the phrase in Section 15 be struck out and that all other vague and ambiguous terms employed in the bill be clarified.

It is the judgment of this committee that the optometrist is not competent to deal with anomalies or diseases of the eye and until by training he can qualify to deal competently with the pathology of the eye in all its aspects, he should not seek the right or privilege to extend his method of diagnosis or treatment.

J. N. G.

In and Out of Focus

BY THE OBSERVER

Is Lay Medical Education Desirable?

There are sharp differences of opinion among physicians as to the value of medical education of the laity. Not a few of those who are most critical of efforts to enlighten the people with respect to the care of their health base their opinions on impressions and their own feelings. Nevertheless, there are others who, having had experience with lay educational programs, still insist that justification for their continuance is questionable.

Dr. Edgar Hull, Professor of Medicine and Director of the Department of Medicine, Louisiana State University School of Medicine, writing in *The Mississippi Doctor* for January, 1946 under the title, "Medical Education for the Laity," takes the opposite view, favoring a carefully conceived program.

> "My interest has arisen because I have observed that the possession of medical knowledge by laymen," Dr. Hull says, "is not always an unmixed blessing; attempts to impart medical knowledge have produced bad as well as good effects. It has occurred to me that some of the unintended consequences may be avoided if the purposes of imparting medical information to the laity are more clearly defined in the thoughts of those who do the teaching, and if the requisites which must be met, if these purposes are to be attained, are carefully considered."

Dr. Hull observes that there are two kinds of education, liberal and useful, and that medical education, "both for the profession and the laity, should be of the same two kinds." He makes a special plea for liberal education, stating:

> "Who can deny that knowledge of medicine, even though it helps us not one whit to stay well or to get well, is interesting and enjoyable; that to have it gives us a sense of self-satisfaction; that medical matters form an absorbing subject of conversation? Knowledge of how we are made, of how our insides work, of the world of microbes, of the diseases that attack man (provided they do not attack us in particular), is intensely enjoyable; of the creations of God, living things are more interesting to most persons than are inanimate bodies; and man is to man the most interesting of living creatures.
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> "It should be noted that most of the articles on medical subjects which appear in lay periodicals and which are read avidly by the public actually have a liberal rather than a practical appeal. Certainly overdramatized articles on hernia, malaria, cure of deafness, the fine art of diagnosis, and the Rh factor are read not because the information is useful, but because it is interesting. (It is unfortunate that from articles of this type the layman often gets liberal misinformation rather than liberal education.)"

Commenting further on the value of liberal education, Dr. Hull has this to say:

> "Knowledge acquired solely for the purpose of enjoyment can often, at a later date, be put to practical use by intelligent persons, and makes even the less intelligent more receptive to practical knowledge which is imparted to them by others. In the field of medicine, accurate though limited knowledge on the part of the laity makes for better, more coöperative patients, and requires much less effort by the public health workers in order to accomplish their aim of improving the health of the people. If people were better educated in medical matters, they would do more of the things that they should of their own free wills, as most things should be done, and there would be less need for coercive legislation designed to improve the public health. The activities of quacks and charlatans would be curtailed because people could see that their claims were ridiculous, and medical fads would be less likely to mushroom because liberally educated persons would reject them as being incompatible with facts which they have learned.
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> "More generally, there can be no doubt that the more liberal is one's education, the more he knows about fields outside of the one in which he works for a living, the better citizen he is. I argue, also, that concentration on purely practical education, even in the case of the less gifted, is a dangerous trend in a democratic country.
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> "As regards utility, medical education of the laity should be considered as having two aims, which though overlapping are nevertheless distinct. The first is to help the individual to improve or to maintain his own

health and to safeguard the health of his family. The second is to effect improvement in the average health of the community, state or nation. In doing his part to accomplish the first aim, the person educated acts as an individual or as a responsible member of a family unit; in fulfilling the second, he acts by carrying out more completely and with better understanding his duties as a citizen."

What, then, are the requisites of an adequate medical educational program for the laity? These are set forth by Dr. Hull as follows:

"First, medical information imparted either for liberal or practical purpose must be accurate; only the truth should be told. As I have already mentioned, much of the medical information given out to the public is, unfortunately, incorrect, so that unhappy results may follow if an attempt is made to use it. As nearly as I can make out, the principal causes of inaccuracy are lack of knowledge on the part of the teacher; his willingness to exaggerate in order to achieve his purpose, be it liberal or practical; and the sacrifice of accuracy in order to achieve simplicity. Lay writers, who prepare articles on the basis of interviews with well known physicians and a little superficial study, are the worst offenders on the first two counts, and professional people on the last, but it is only fair to say that inaccuracies due to all three factors are not infrequently detectable in the efforts of physicians to educate the laity.

"Second, it must be understandable. Facts must be presented in words the meaning of which is known to laymen, the presentation being carefully designed for complete comprehension by the persons to whom they are to be imparted. The net result of presentations which are not understood is the dissemination of inaccurate information. It must be realized that this requisite automatically limits the breadth of the medical education of lay persons. What the layman cannot grasp, he should not be told. I believe that physicians, in explaining to patients the nature of their illnesses, are the ones who violate this requisite most frequently; the amount of medical misinformation, widely spread by word of mouth, which emanates from this source, is astounding.

"Third, it must be authentic; that is, it must consist of established facts about which medical authorities are in substantial agreement. New concepts and unproved claims should be presented to the profession and subjected to proper confirmation before they are given to laymen, who are unqualified to judge the points at issue. Premature release of claims not yet subjected to criticism and adequate trial leads to false concepts and confusion, and often makes things very difficult for the conscientious practitioner who learns of advances in medicine from medical journals rather than from the daily papers or weekly news magazines. One of the most harmful trends conceivable is the present tendency of lay writers in popular magazines to discuss controversial medical problems, and then presume to decide which side is right and which is wrong. Usually the 'old guard' are discredited and pictured as obstructionists to medical progress; the conclusions may lead to lack of confidence in the conscientious scientists who realize that change and progress are not necessarily the same."

Dr. Hull is not oblivious to the criticism leveled at the program which he so adequately describes. He is well aware of what he calls "negative requisites" which he describes as follows:

"First, medical education should not engender fear, or tend to cause people to become abnormally preoccupied about their health. Although fear is a potent stimulant of positive action, it is also one of the most potent factors in the etiology of the neuroses, which are more common and distressing than the organic diseases. Even the most carefully presented facts about disease may precipitate neuroses in susceptible persons, among whom are many of the most avid lay students of medicine. Exaggeration designed to produce action may cause neuroses even in well balanced persons. I have seen many a normal person made miserable by fear of venereal disease, cancer, heart disease, or tuberculosis, produced by efforts to control these diseases through education. This requisite is best fulfilled if medical instruction appeals to reason rather than to emotion.

"Second, it should not give rise to false hopes. Such hopes are not likely to arise if medical instruction is truthful, authentic, and understandable, but because some of these requisites often fail of fulfillment, much unhappiness has been produced. Persons with advanced hypertensive disease have flocked to surgeons whose operations on the sympathetics have been publicized, or have pleaded for kidney extracts which have never been advanced beyond the experimental stage; sufferers from crippling arthritis have expected complete restoration of function from injections of gold; miracles are expected, almost demanded of the new antibiotic drugs, some of which are not yet even available to the practicing physician. Most of the false hopes arise out of unauthentic or misunderstood information."

Advantages of a Unified Command

If space is infrequently given in this column to material from county medical society bulletins, it is not because your Observer is unappreciative of their worth. For some are excellent both from the standpoint of subject matter and the way in which it is handled.

None of the bulletins is journalistically superior to the *Bulletin of the Hennepin County* (Minneapolis, Minn.) *Medical Society*. One may or may not agree with the editorial views expressed in this publication but one's interest never lags because the editor is a writer of talent and experience. The *Bulletin* is usually not guilty of "straddling the fence" on vital issues although there is a tendency at times to tread softly. For example, it is no secret that medical men "in the know" are perturbed by the multiplicity of organizations that claim to have the physician's interest at heart. Although most of them seek the defeat of the Wagner-Murray-Dingell bill, each has its own idea as to how this can be accomplished. Most disturbing is the report that representatives of all these groups propose to descend on Washington for the hearings on the bill. If they do it will be too bad for medicine.

The *Bulletin* takes cognizance of this situation in a cautiously written editorial entitled, "E Pluribus Unum." "It is not intended to challenge the right of physicians to organize or support associations and committees which function outside the American Medical Association," the *Bulletin* states, "nor the announced good intentions of those responsible for these groups. However, one still may question the necessity for some as well as the judgment of their founders. It is a matter of record that when any group grows impatient with the AMA's deliberate course of action, dissatisfied with its 'inaction' or its 'standpatism'—all these terms have been applied—it is the customary course to rush out and form another organization, one which is advertised to be more militant, more active, more practical—these and more expansive adjectives have been used to describe platforms. The Biblical injunction to be fruitful and multiply is taken seriously.

"Thus we have the Association of American Physicians and Surgeons, the 'Committee of 400,' the National Physicians' Committee, the Physicians' Forum, the United States Public Health League and now the Conference of Presidents and Other Officers of State Medical Societies has evidenced its intention to become a permanent organization. All these have the announced purpose to aid the cause of medicine according to their lights, lights which may or may not be beamed to that of the parent organization.

"Of these, the National Physicians' Committee and the United States Public Health League can show records of real accomplishment and definite value but whether these should continue an independent existence—an independence the authenticity of which is questioned in some quarters—or be welded into an enlarged public relations program for the AMA, probably is a matter for future decision. As to the others, there exist sharp differences of opinion as to their necessity and their objectives.

"That the American Medical Association is the official organization of medicine, cannot admit of debate: as such, an increasing number of physicians hold the opinion that the AMA alone should speak for medicine. While its House of Delegates is representative although not truly democratic, it stands as the duly constituted policy making body and the official voice of the profession. Changes in its membership and policies are not impossible to accomplish: Those who are unhappy or dissatisfied can, providing they have a platform which merits sufficient support, effect such changes. This course would seem more logical than one which, to many observers, constitutes a mild form of secession.

"In all events, it should be plain that the present multiplicity of lateral organizations divides medicine's strength and resources, complicates the matter of public relations and spreads thin the efforts of the profession. To those outside medicine, the picture must appear strange, indeed. Within the profession, the situation creates confusion and doubt. Small wonder that there are those in Washington who listen to groups which are more powerful vocally than numerically and who speak with an authority which would be difficult if not impossible to establish.

"In both World Wars, it was demonstrated that there are great advantages in a unified command and a single board of strategy, a lesson which some elements in medicine could study with profit to themselves and considerably greater profit to the profession as a whole."

Your Observer would go further than the *Bulletin* and say that unless we have a "unified command"—and that soon—we are inviting disaster. He too would distinguish between organizations, their methods, and attitudes, but he believes that only one should speak for organized medicine, that is, the American Medical Association. If the Association is not capable of doing so adequately our plight is sad indeed.

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Does President Truman Approve?

Too often we take things for granted only to discover that what we believed to be the facts just aren't so. Most physicians, for example, are under the impression that President Truman has endorsed the Wagner-Murray-Dingell bill. But is this a fact?

On November 19, 1945, President Truman delivered his historic health message to the Congress. In this message he endorsed compulsory health insurance and called upon Congress to enact health legislation incorporating this feature. On the morning following delivery of his message, a revised Wagner-Murray-Dingell bill was introduced. The conclusion was immediately drawn that the President had paved the way for this legislation. But any such conclusion is hasty and is not borne out by the facts.

To your Observer's knowledge the President has not uttered a word one way or the other with respect to the Wagner-Murray-Dingell bill. As a matter of fact, it is known that he is studying the whole matter and has not yet made up his mind as to the exact type of legislation he will approve. He is deeply interested in medical care and believes something must be done to improve its distribution. As stated previously in this column, he has little confidence in leaders of organized medicine. This is unfortunate and, in your Observer's opinion, not readily remedied. But it is not an insurmountable obstacle although there is little possibility that this administration will become friendly to organized medicine unless there is a change in its leadership.

It is your Observer's guess, and it is only a guess, that if the President does approve a health bill incorporating the features described in his health message, it will not be the Wagner-Murray-Dingell bill.

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On Making a Health Inventory

It is often the case that physicians who are nationally known are comparative strangers to the medical profession in the communities in which they live. That is not exactly true of Dr. Edward J. Stieglitz; who for some years now has been practicing in Washington. Nevertheless, he is a modest, likable man of considerable talent with whom many of our physicians have not yet become acquainted. At least they are not familiar with the fact that he is known nationally as an author, educator, and investigator.

For some time, Dr. Stieglitz has been interested in preventive medicine, especially in its application to adults. Selected by the New York Academy of Medicine's Committee on Medicine and the Changing Order as a "recognized expert" in this field, he was asked to prepare a monograph to which he gave the title, "A Future for Preventive Medicine." Recently it appeared in book form, and it is to be hoped will be widely read by physicians.

Of particular interest to your Observer were Dr. Stieglitz's views on preventive, or what he calls "constructive," medicine as applied to the individual.

"In addition to what we may call the wholesale or public measures of preventive medicine," Dr. Stieglitz writes, "there exists the potentiality of developing a personal or private form of health improvement. Though all will agree that the species man has many attributes common to all its members, we must not forget that there exists considerable variation in individuals. Of necessity these individual differences must be ignored in any wholesale approach. This leads to an inevitable reduction of the benefit of preventive measures, correctible only by individualization in guidance. Variation in different persons increases with age.

"Yet in spite of the obvious importance of applying to mature adults personal and individualized guidance toward health construction, it is conspicuous that thus far this type of approach has been developed entirely in the fields of pediatrics and obstetrics. That pediatricians have succeeded in their program of making well babies and children healthier is well known. There are many 'well baby clinics' scattered throughout the land, clinics associated with medical schools and hospitals, and also mobile clinics operated by maternal and child health organizations, both public and private. Their accomplishments in health construction need no review here. But 'well adult clinics' are virtually unknown. The implication is clear: individualized constructive medicine for adults, and particularly for senescents, should become a significant element in future preventive medicine.

"The control, prevention, and retardation of the common and increasingly significant degenerative diseases can be accomplished only by such individual attention. Each and every instance presents an individual diagnostic and therapeutic problem, for the etiology of such disorders as arteriosclerosis, hypertensive disease, and diabetes mellitus consists of many factors, differing in each case. Wholesale or public health measures are utterly useless. The cumulative insults of infections, intoxications, traumata, deficiencies, excesses, and fatigues which constitute the inevitable vicissitudes of existence differ in different people. They vary in character, intensity, and sequence. We are what we are today largely because of what happened to us yesterday and everyone has had a different series of yesterdays.

"One essential difference between the problems of individualized preventive or constructive medicine for adults and that so successfully practiced for children is that in the latter instance the physician may assume with relative assurance that the child is healthy unless acutely ill, whereas in geriatric practice the contrary applies. An older person is almost never wholly 'normal' and certainly never ideally in the fullest possible health. The scars of having lived are inevitable. The borderline between disease and the normal depreciations of aging is hazy and wide. Therefore it becomes obvious that the primary and preliminary requisite to individual guidance to greater health is analysis of the status of health of the person involved. The foundation of personal preventive medicine is the periodic health inventory. The measurement of health, which is always relative, and the diagnosis of frank disease are entirely different matters. The first is much more difficult, more expensive, and more time consuming, for it involves search for and recognition and evaluation of very minor and subtle deviations from normal. We cannot rely upon obvious symptoms or signs.

"The term 'health inventory,' instead of the commoner designation 'periodic examination,' is applied deliberately, for a properly conducted study is far more than a routine clinical physical examination. Furthermore, the implications of the term 'inventory' are understood by all. It has been surprising to note how much greater coöperation and appreciation of thoroughness one obtains from patients when the study is described as an inventory rather than as an examination. No man of business expects his factory or store to undergo an inventory in an hour or so, but he is very likely to report to his physician and say: 'Listen to my heart today, Doc, and tell me how I am.' As the effectiveness of the periodic inventory is totally dependent upon the initiative and coöperation of the patient (herein personal preventive medicine differs most conspicuously from the public health), the element of willingness to coöperate is of the utmost importance."

The objectives of the health inventory, Dr. Stieglitz says, are:

"First and foremost is analysis of the health status of the patient and interpretation of the probable effects of his previous life upon the physical organism. Second is prompt correction of remediable defects. Third is advice and guidance regarding habits of life which may be potentially detrimental to the specific individual. A very important part of such an inventory is searching inquiry into the habits of life, wherein are included such factors as fluid intake, diet, occupation, rest, exercise, sources of anxiety, utilization of leisure, mental habits (such as exaggerated worry), alcohol, and tobacco. Such data probably give as much information regarding the personality as a whole as can be obtained in a reasonably short period of time. The fourth objective of the periodic inventory is determination of the capacities and limitations in connection with work. This is particularly significant where the occupation involves any unusual stresses of either a physical or a mental nature. For example, it is the responsibility of the flight surgeon to ground flying personnel when they show evidences of fatigue, before a crack-up leads to serious or fatal injuries not only to themselves but also to others. Similarly, it should be the responsibility of physicians conducting health maintenance services to urge temporary or permanent alterations in occupations of individuals carrying an exceptionally heavy intellectual or moral responsibility upon the detection of evidences of arteriosclerotic cerebral degeneration. The last, but not least, important objective of the periodic inventory is personally applied education in hygiene."

Your Observer regrets that space will not permit further quotations from Dr. Stieglitz's book, for what he has to say is stimulating reading. One may not agree with all of his conclusions but they point up the fact that the medical profession can do a much better job of disease prevention in adults. In fact, in this respect the profession's efforts are obviously inadequate.

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Industrial Fee Schedule Adopted

The long, arduous task of preparing new regulations and an adequate industrial fee schedule was completed by the Society's Committee on Industrial Medicine some months ago. Prior to their adoption by the Society on March 6, 1946, ample opportunity had been given the membership to digest and comment upon them. With few exceptions, there was general approval of the Committee's handiwork.

As will be recalled, the "General Information and Regulations for the Guidance of Physicians Engaged in Practice under the Workmen's Compensation Act with Appended Fee Schedule" was mailed to the membership well in advance of its presentation to the Society. Forms were enclosed on which members could indicate their approval or disapproval. One hundred and seventy-seven stated that they were in favor of the schedule and 13 were opposed. The Chairman of the Committee conferred with those who dissented, discussing with them the various aspects of the fees. The result was that, with the exception of a very few items, it was not necessary to make any changes in the schedule approved by the Committee.

For the most part, the few demands made for change could be acceded to, but not in every case. There was one point on which legal advice was sought. This was whether adoption of the schedule by the Society bound members individually to adhere to it. The Society's legal counsel observed:

> "It is my opinion that the fees to be charged by physicians for services rendered to their patients are matters of contract between physicians and their patients. This contractual principle applies to Workmen's Compensation cases subject to the qualification that where the amount of a fee for professional services rendered becomes a matter of dispute in a compensation case, the Compensation Commission has jurisdiction to determine and adjudicate the amount of the fee to be paid for such services."
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> "Of course, as a practical matter, a physician should realize that where a recommended fee schedule is adopted by such a body as the Medical Society of the District of Columbia, and fees recommended in the schedule thereafter usually are charged for the performance of services in compensation cases, it would seem to follow that such a schedule, while not legally binding, might have persuasive force before the Compensation Commission in any controversy involving the reasonableness of a fee for services rendered in such cases."

It is clear, then, that where a physician believes his services are worth more than the schedule adopted calls for, he can increase his charges provided he obtains the approval of the insurance carrier before undertaking treatment. Naturally he must justify charges beyond what the schedule calls for. By and large, members have indicated they will adhere to the schedule, which is as it should be.

In recommending to the Society the adoption of the schedule proposed by the Committee, the Executive Board stated:

> "It is not intended that this fee schedule shall remain in effect indefinitely. In fact it is recommended by the Chairman of the Committee that it be revised again next year and each year thereafter in order that it may be complete and up-to-date. It should also be understood that changes in it may be proposed at any time through the Committee."

It was pointed out, too, that the fees listed are as high as any in the country for compensation cases; furthermore, that the fees listed in each specialty have been discussed with many members, singly and in groups, in an effort to arrive at fees acceptable not only to physicians but to insurance carriers.

Dr. W. Cabell Moore, Chairman, and members of his Committee are deserving of commendation for a task well done. It is only fair to mention the fact that most of the work fell to Dr. Moore. He gave unstintingly of his time, keeping right at his assignment until it was finished. Members of his committee have much praise for him.

Copies of the adopted regulations and fee schedule will soon be available at the Society's office.

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Los Angeles' Indoctrination Program

On various occasions members have said to your Observer that it should be made more difficult for physicians to become members of the Medical Society of the District of Columbia; that the highest possible qualifications should be required of applicants. No one can quarrel with this view. In fact, officials of the Society have long been of the same opinion and due to their insistence, steps in this direction have been taken over a period of several years.

Recent changes in the Society's Constitution and By-laws, for example, provide further protection against undesirable physicians. An applicant for membership must now submit his application endorsed by three Active members. His name is then published and read before the Medical Society. Nearly two months are allowed to elapse before he is requested to appear personally before the Board of Censors which recommends his election or rejection to the Executive Board. Election by the Executive Board is now subject to final confirmation by the Society itself within one year. Thus, there is ample time to determine the desirability of an applicant for membership in the Society.

The Los Angeles County Medical Association not only exercises care in electing new members but it has adopted what is called an indoctrination program for applicants for membership. The program calls for mandatory attendance at a series of six lectures, two to be given each month, to be followed by an examination to discover whether these applicants have really gained anything from these lectures. Subjects discussed are: Medical Organization, Health Insurance, Medical Public Relations, Medical Ethics, Medical Education and Medical Economics, and Medical Malpractice.

The Association has set up a general indoctrination committee and six subcommittees of four members each. Each subcommittee has a specific lecture to manage. Inasmuch as there are four series running during the year, members of the subcommittees are not overworked, two members of a committee handling a lecture. This means that members of subcommittees appear only twice a year before the neophytes.

Commenting on this program, Mr. Stanley K. Cochems, Executive Secretary of the Association, writes, "While at the present time [it] is somewhat of a headache, [it] will be a most valuable procedure, not only to build up the strength of our Association, but to aid the new men materially in meeting the unusual conditions of medical practice we find here in California . . ."

"Reaction of the applicants is very favorable. Some of them growled when they were notified of the program, but when the individual who was growling learned that he was but one of two hundred odd at the meeting, he suddenly developed the spirit of one who wanted to join the Ku Klux Klan and had found the opportunity."

The Los Angeles County Medical Association is to be commended for its forward-looking program. There is no better opportunity to enlighten physicians on subjects which they later often ignore than when they apply for membership. Your Observer will watch the progress of this effort with more than ordinary interest.

Attention of the Medical Society's Executive Board was called to this program at a recent meeting. The Board decided it was not practical in Washington at this time. However, it was proposed that recognition be given new members and that a reception for them be sponsored once a year by the Membership Committee. This proposal has been referred to the Committee for its consideration.

"the Fly in the Ointment"

Physicians are well acquainted with the financial problems which harass medical students. For many of them have personally experienced the difficulty of making ends meet and can testify to the bitterness of the struggle. Some of the more hardy married while in medical school. As might be expected, their financial troubles multiplied, unless they were fortunate enough to have found a mate who had an independent income or was capable of earning one. Even then, it was not easy going.

Not long ago a wife of a medical student and intern had her say on this subject in the *Baltimore Evening Sun*. More articulate than most, what she has to say is well worth reading.

> "Those of our grandfathers who chose medicine as a profession," she says, "entered upon a three-year medical education with only a highschool diploma in hand and, having received their degrees, humbly went out into the world to discover what medicine was really all about. A great many of them then married. A young doctor at the beginning of this century could manage to start a home and family with no great difficulty by the time he was 24. Now a young physician is at least 26 before he is ready to start a general practice and probably more than 30 before he is prepared to begin as a specialist. Six or ten years to wait for marriage make a difference because none of the other considerations has been changed to keep pace with the lengthening of a doctor's education.
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> "Yet in all of the branches of medical society it evidently has not occurred seriously to any one of the trained, intelligent people therein to offer any concrete solution for the dilemma of a young man of perhaps 21, about to enter medical school, who happens, by some peculiar twist of nature, to be in love and eager to marry. Most American youths, like all other normal human beings, are eager to create homes of their own.
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> "However, the fly in the ointment of most young medicos' plan is finances. Even without marriage, the average student is faced with a certain amount of financial difficulty in completing his education. Unless his parents or relatives are willing to give him the necessary funds, he must borrow and work to earn a part of the expense. We will suppose that he has gone through his premedical curriculum rather precariously, but now stands at the threshold of medical school, still working hard and borrowing. He is 22 and happens to be interested in marriage. With perhaps some hesitancy, but with greater determination, he marries.
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> "Naturally, there must be economic sacrifices, and most young couples who marry while the man is a student have accepted this fact and are willing to suffer the necessary deprivations and limitations until the schooling is completed. The wife will work. Forty dollars a week, if she is fortunate enough to earn it, is enough to live on economically, but it is not enough to furnish the extra needs that a pre-professional man and his wife will encounter. With the combined strains of studying, working, housekeeping and financial juggling, the couple will require a generous amount of resistance, humor and courage. Graduation is usually hailed with deep relief.
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> "Here the problem changes. By now both marriage partners are quite naturally tired of the struggle. The wife may be tired and rundown from the double life she has been leading and the husband is mentally tired of the social implications affecting any man who cannot support his own wife and home.
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> "He enters a hospital to serve his internship and, in spite of a doctor's degree, he earns—in a good hospital—anywhere from nothing to $50 a month. He works hard on an average of twelve hours a day plus every other night and week end, yet he is not paid as well as the hospital kitchen help.
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> "It may be argued that he is still receiving an education. But he is not only learning; he is also performing highly specialized work for someone else's benefit, and by all of the common rights of man and decency, he should be adequately paid for it. The hospitals benefit by a kind of slave labor."

The distressed wife then asks, "Is there any intelligent reason why a doctor should have to go through such a purgatory in order to be successful?"

To which she gives this reply:

> "Such an idea as this fire-and-brimstone education for beginning doctors is preposterous. With more adequate pay and less tedious conditions, I believe that an internship would far more efficiently serve its educational purpose."

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Which Are You?

Annual addresses made by presidents of medical societies follow pretty much the same pattern. They take into account past and present performances and promises for the future. Usually they are well seasoned with self-praise. Sometimes the president has an original idea or he dresses up an old one so that at least it seems original. A few are thoughtful, scholarly and generally well informed.

Dr. Thurman B. Givan, President of the Medical Society of the County of Kings and the Academy of Medicine of Brooklyn, in his inaugural address given on January 15, 1946 presents a comprehensive review of his society's activities, the general medical situation, and the attitude of physicians toward the world in general. His observations with respect to the latter held special interest for your Observer.

"The pessimist sits and looks through a glass darkly—often only seeing red," Dr. Givan observes. "As he peers, he sees this country 'going to the dogs,' and pretty soon. A new type of government is to supplant that which our forefathers produced—even perhaps communism is knocking at our gates. And those pessimists who are medical-minded look and see the bureaucrats taking over, lock, stock and barrel, all types of medical practice. There are those among us—yes, medical men—who are joining with the bureaucrats in having medical practice administered by a small group of selfish-minded people. The politician among them sees accruing to himself more power by which eventually he may control more votes. The medical man who goes along with him imagines he will gain influence for the small group surrounding him. After all, money for future large endowments may be limited, for the rich undoubtedly will be fewer. Funds from the public treasures will become more and more enticing. Thus ways and means must be found to extract goodly sums from this source for various medical enterprises. . .

"Other pessimists point to the failure of socialized medicine in Germany, of how in spite of many years' experience with medicine run by the State in Russia, that country is far behind this country in medical progress so far as the health of the masses is concerned. They point to the panel system as practiced in England and that that country has not surpassed us in health measures. All these things are without doubt true. The pessimist fears one of these systems may be applied here. Thus medical progress would be halted—and halted it surely would be—because far over one hundred thousand physicians in this country would not be back of any such plan, and I don't believe they will have it thrust down their throats. What will the pessimist do to prevent such a debacle from happening to the people of the United States? Nothing.

"The medical optimist looks through a clear glass, yes, perhaps a magnifying glass. He sees not only a glorified past of medical achievements in this country. He watches from far back in our history the practice of medicine lagging far behind such countries as Germany and England.

"Our physicians went to Europe to gain advanced knowledge. This continued until the past quarter of a century when there was no further need for a young physician to seek his postgraduate work in any foreign country. The Unites States had already passed the world in medical knowledge. This was accomplished by the gradual development of the best all-round undergraduate system of teaching students in more than fifty medical schools throughout the country. Supplemental to this was the concomitant organization of hospitals with their intern and resident training. Added to this are the instructive hospital clinical and pathological conferences, the local medical societies, as well as the State and National Medical Societies. And do not forget our comprehensive current medical literature and libraries. All these facts have combined to make the physician of this era in our country the best trained of the entire world. He is equipped to give the public the best medical service ever known to mankind. No wonder, then, the medical optimist sees a bright future. By the same token he is not going to allow bureaucrats to unburden their load of untried medical ideas upon him; certainly not without a fight to the finish. This does not mean that there will not be rather radical changes in medical practice. Undoubtedly there is need for a change along certain lines. Those of us who have been content to live and let live may find these changes at first rather irksome. Yet those who are leaders in our profession must take part actively in whatever reforms are to be tried . . ."

"The pessimist will continue to face westward toward the setting sun but instead of the sun he sees ominous clouds boiling before the tornado is turned loose. The optimist looks eastward and observes a vista on the horizon of a rising sun in all its glory—that is his medicine of the future."

Let's have more optimists!

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Postgraduate Course in Diagnosis No committee of the Society has received more enthusiastic support from the membership than the Committee on Postgraduate Education. This has been gratifying from many points of view. First of all, it is evidence that Washington physicians seek to improve themselves and are generally desirous of becoming better doctors. Successive committees, too, have learned something about the type of postgraduate courses which will attract physicians in practice. Subject matter, they have found, must be chosen with care. The average medical practitioner is not interested in research, and abstract dissertations bore him. However he participates enthusiastically in discussions and demonstrations which are of value to him in everyday practice.

This year's Committee on Postgraduate Education made a particularly happy choice in the POSTGRADUATE COURSE IN DIAGNOSIS. The response was more enthusiastic than in any previous course. Fortunately, the lecturers lived up to expectations and presented their subjects most effectively.

As a list of the speakers and subjects has not previously appeared in the MEDICAL ANNALS, it is published herewith for the record.

February 4	"Acute Cardiac Emergencies" TINSLEY R. HARRISON, M.D., Professor of Medicine, Southwestern Medical College, Dallas
February 11	"Vascular Accidents of the Extremities" ALTON OCHSNER, M.D., William Henderson Professor of Surgery, Tulane University School of Medicine, New Orleans
February 18	"The Acute Abdomen with Special Reference to Differential Diagnosis" CALVIN W. SMYTH, JR., M.D., Associate Professor of Surgery, Graduate School, University of Pennsylvania, Philadelphia

Enrollment in the course topped previous records, there being 314 physicians who registered, and 109 interns and medical students.

The Committee, of which Dr. Robert H. Groh is Chairman, is to be congratulated on the success of the course. Dr. Groh has announced that another course in diagnosis may be given later in the spring.

There Is a Difference

The laity has many misconceptions about physicians, one being that because of their medical knowledge they escape many of the physical and mental ills which burden ordinary mortals. Of course, this isn't true. In fact, physicians are, on the whole, short-lived and suffer the same disabilities that other human beings do. Unfortunately, they are also equally negligent of their health.

If there is a difference between the layman and the physician it is that the latter, knowing a great deal more about the human machine, becomes more readily concerned about his health. In consequence, many of them are worriers. They are prone to place the worst possible significance on symptoms which might well go unheeded. Some, if they are wise, become philosophical about it all, others go on worrying. This state of affairs came to mind when your Observer read some observations on worry by Dr. F. A. Willius of the Mayo Clinic, which recently appeared in *Medicine*. Dr. Willius wrote:

> "It is doubtful that any person has entirely escaped worry. It is useless to tell an individual not to worry although the problems which comprise the basis for worry usually do not eventuate into realities. The trivia of life which for the time being loom with the magnification of twilight shadows occupy much attention while actual impending calamities usually occupy only a small part of an individual's consideration. At this point in the discussion it becomes desirable to distinguish clearly between the act of worrying about a problem and being concerned about a problem. Worry, which is a protracted or recurrent act of mind, follows devious and complex courses, always fails to result in a constructive solution of the question and eventuates in confusion, fatigue and emotional instability. Concern, on the other hand, comprises interested and usually deliberate consideration of a problem in an orderly manner, with acceptance or rejection of apparent facts and contradictions. Concern ultimately results in an acceptable conclusion. Even though the conclusion is contrary to the individual's wishes, it is accepted philosophically and owing to the fact that a definite conclusion has been reached, the effort has been constructive. Thus, the nervous energy expended has not been unproductive and confusion of thought has not prevailed."

In which category are you, doctor?

Footnotes There are always a few matters about which your Observer would like to comment briefly; hence "Footnotes" will become more or less a regular feature of this column. . . . Response from members in the first week following the mailing of the Committee on Medical Care's proposed prepayment plan was somewhat disappointing. Frankly, the number of replies was not what had been expected. However, returns were stimulated by a postcard sent to the membership. At the time this is written (two weeks after the mailing) more than 300 have replied. All except a few are in favor of the Committee's plan, with a considerable number believing that there should be modifications. There is no doubt that changes will have to be made in the plan before its adoption. However, this is not a serious obstacle. The next step then will be for the Committee to make an analysis of the returns and to consider the changes proposed. Sometime in April there will undoubtedly be a meeting of the Society called especially for the purpose of taking formal action on the plan. Your Observer is very much encouraged by these developments, which seem to indicate that the plan with modifications will be adopted. . . . Many communications have been received by your Observer. In view of their complimentary character it would be rather immodest to publish them. However, your Observer believes he is justified in mentioning them here and to express his appreciation for the kind things said about "In and Out of Focus." They have been good for his morale and will keep him at what often seems an endless, but not unpleasant, task. . . . The recently announced death of Dr. Frederick C. Warnshuis stirs memories of the past. Few physicians in your Observer's recollection possessed greater natural qualities of leadership than Dr. Warnshuis. For many years he was Speaker of the House of Delegates of the American Medical Association. No better Speaker has ever wielded the gavel in the House. From the time he was dislodged from this position his fortunes began to wane and in his final years he passed into obscurity. Those who remember him in his prime will regret more than his passing the fact that his period of considerable influence for good in medicine was so brief. He was a capable, forceful leader who, lacking self-discipline, fell by the wayside before his time. At his best he would have been a great asset to organized medicine in these tumultuous days.

T. W.

PHYSICIANS' EMERGENCY PARKING PRIVILEGES JEOPARDIZED

One of the most valuable privileges granted physicians in the District of Columbia in recent years is the right to park in emergencies in specified restricted zones. The present arrangement has been in effect since March, 1943, and all in all has been very satisfactory.

It was emphasized in the very beginning that physicians must observe the rules agreed upon at a conference of representatives of the Metropolitan Police Department, the Department of Vehicles and Traffic, and the Medical Society of the District of Columbia. In general, there has not been too much reason for complaint on this score. At one time a letter was received from Inspector Miller of the Police Department calling attention to infractions. A notice was immediately dispatched to physicians and no further difficulties were reported. However, another communication has just been received from Major Harvey G. Callahan, Superintendent of the Police Department. Under date of March 8, 1946, Major Callahan writes:

> "It has been brought to my attention that some members of our department and certain members of your Society are not thoroughly familiar with the provisions of our agreement relative to granting certain concessions to doctors on urgent professional calls with respect to parking their cars.
>
> "The commanding officers of this department have again been advised of these concessions, and it will be appreciated if you could advise your members through your bulletin or whatever means you deem appropriate.
>
> "The agreement, as you will recall, was that members of the Medical Society of the District of Columbia would be issued a card by you to be displayed on the inside of the

windshield of their cars *only* when on an *urgent professional call.*

"I am sure you have the list of offenses which would be condoned, as well as a list of those which could not be violated.

"It appears that many doctors have the distinct impression that this card can be used, and should be honored by officers, when making regular professional calls and, in fact, quite frequently when making purely personal calls.

"If a doctor should receive a traffic violation notice when on an urgent professional call, he should contact the Captain or Lieutenant of the precinct or bureau to which the officer is attached. If the facts justify such action, the ticket will be adjusted.

"We are very happy to assist doctors in making emergency calls and will continue to do so, but an abuse of these privileges may make it necessary to cancel this agreement."

Needless to say, continuance of special parking privileges is now up to physicians to whom cards for this purpose have been issued. For the benefit of those who may have obtained cards but for some reason or other failed to obtain a copy of the rules agreed upon, they are reprinted below:

1. The car must be properly identified by an appropriate insignia.
2. The doctor must be on a professional call to patients seriously ill, with no legitimate space immediately available within a reasonable distance.
3. The following places may be used:
   (a) Entrances to apartments.
   (b) Commercial vehicle loading zones.
   (c) Places set aside for holders of official parking permits.
   (d) Approach end or "heel" of a bus zone.
   (e) Side of a street which is restricted at all times.
   (f) Restricted zones approaching signal lights, but not at stop signs.
   (g) Alleys if a space of ten feet is left open.
   (h) Abreast away from corners on wide streets or streets where traffic is light.
4. There must be no parking on streets restricted for "No Standing" within certain periods, on taxicab stands, by fireplugs, so as to obstruct crosswalks, or between platforms and the curbs.

It is exceedingly important that physicians observe these rules. Unless they do, special privileges will be withdrawn.

Members desiring a copy of the above rules for their files should call the Medical Society's offices, District 3111.

No further comment on the situation is needed than to say that it is hoped by officials of the Medical Society that members will observe the rules so that there will be no danger of the present privileges being discontinued.

NURSES' RECRUITMENT PROGRAM

The fact that the war emergency is over has not caused the nursing situation in our local hospitals to improve. In fact, in some hospitals a worse shortage exists than at any time during the War, due to the fact that many married nurses, helping out for the duration, left as soon as their husbands returned from overseas. Others who were carrying a double load during the war—running a home, and helping out in the hospitals—left to take better care of their families.

Termination of recruitment of student nurses by the U. S. Cadet Nurse Corps had its effect on student nurse enrollment. Beginning classes in many hospitals are only partially filled. This is very expensive and presents a serious problem to the hospitals, which are trying to build up nursing personnel commensurate with the increased patient load, which seems to be in Washington to stay.

Then again, the two new hospitals which are being built will need an increased staff of graduates and students. Interest is always high in new hospitals so these institutions may not suffer, but if they do not others will, because they will have lost many potential students and graduates to the new hospitals.

Realizing all this, the Graduate Nurses' Association is planning a very active and, we hope, good recruitment and publicity program through its committees on nursing information and recruitment.

The program to date is as follows: The Commissioners are designating the week of May 5–11 as Student Nurse Recruitment Week. This week was chosen because of May 12, which is Hospital Day. The public, and especially high school students, will be invited to visit the hospitals on this day. Student

Nurse Recruitment Week is being sponsored by the Washington Board of Trade. Newspapers, radios, shopping news, and *Capital Transit News* will carry publicity.

Churches are being contacted to ask ministers to make appeals to young women to seek a career in nursing. A letter was written to the Superintendent of Schools to ask students in the Art Departments to make posters. Speakers will appear at Parent-Teachers' Meetings and at Citizens' Association meetings. All D. C. and nearby Maryland and Virginia high schools will hold assemblies during the first two weeks in May; a graduate and a student from each hospital will be assigned to a high school to speak on nursing; a sound film showing the student nurse all through training will be run.

Following is a list of the Schools of Nursing in the District of Columbia and their entrance dates.

Classes Begin	*School*	*Apply to*
July	CAPITOL CITY SCHOOL OF NURSING Gallinger Municipal Hospital 19th and O Streets, S.E.	Miss Beatrice Ritter, Superintendent of Nurses
September	EMERGENCY HOSPITAL 1711 New York Avenue, N.W.	Mrs. Ruth Woods, Superintendent of Nurses
September	FREEDMEN'S HOSPITAL 6th and Bryant Streets, N.W. (Colored students only)	Miss Ella Jackson, Superintendent of Nurses
June and September	THE LUCY WEBB HAYES SCHOOL OF NURSING The American University Sibley Memorial Hospital Massachusetts and Nebraska Aves., N.W.	Miss Gladys Jorgenson, Dean
September	GARFIELD MEMORIAL HOSPITAL 10th and Florida Avenue, N.W.	Miss Shelby Patton, Superintendent of Nurses
September	GEORGETOWN UNIVERSITY HOSPITAL 35th and N Streets, N.W.	Miss Anne Murphy, Superintendent of Nurses
July and September	PROVIDENCE DIVISION, SCHOOL OF NURSING EDUCATION The Catholic University of America	Sister Rita, Superintendent of Nurses
September or October	ST. ELIZABETHS HOSPITAL Congress Heights, D. C. (Mental and Nervous Hospital)	Miss Edith M. Haydon, Superintendent of Nurses

ENTRANCE REQUIREMENTS

Age: 18 to 35, with some exceptions.

Academic Requirements: Graduation from an accredited high school, from upper half of class, with at least 16 units, proportioned as follows: English, 4 units; science (preferably general science and a second science such as chemistry or physics), 2 units; mathematics, 2 units; social studies (1 unit must be U. S. history, except that $\frac{1}{2}$ unit of civics may be substituted for $\frac{1}{2}$ unit of U. S. history), 2 units; electives, 6 units. Nurses' Examining Board gives special consideration to record of unusually good candidate even though it may not satisfy all requirements. It is suggested that candidates contact and visit at least two local schools of nursing before choosing a school.

STREPTOMYCIN ALLOCATED FOR CIVILIAN USE

The Army Medical Department, which has received many requests for supplies of streptomycin to be used in treating civilian cases, announces that all civilian inquiries and requests for this drug are to be sent to Dr. Chester S. Keefer, Evans Memorial Hospital, 65 East Newton, Boston, Mass. Telephone Kenmore 9200.

Dr. Keefer is Chairman of the Committee on Chemotherapeutic and Other Agents of the Division of Medical Sciences, National Research Council, and has been authorized to handle civilian requests, providing they are submitted by a physician giving sufficient technical information to enable him to decide whether streptomycin is indicated in the treatment of the case.

Distribution of limited supplies of streptomycin to civilians through the Committee on Chemotherapeutic and Other Agents of the Division of Medical Sciences, National Research Council, has been provided for in the allocation program recently established by the Civilian Production Administration. Other agencies receiving allotments of the scarce drug include the Army, Navy, Veterans' Administration, and the United States Public Health Service.

Although there has been a general misconception that the Army controls the total streptomycin supply, actually an approximate 30 per cent was allotted to the Army from the production for the month of March. The bulk of the limited supply received by the Army has been employed in treating urinary tract infections associated with spinal cord injuries, and a few serious infections which have proved resistant to penicillin. At no time has the allotment been adequate to permit any extensive research, such as experimental work on the treating of tuberculosis. In order that Dr. Keefer may obtain an adequate supply for civilian appeals, the Army voluntarily agreed to a delay in its March delivery of streptomycin from producers.

Grants-in-aid of approximately $500,000 for the clinical study of streptomycin, contributed in equal shares to the National Research Council by eleven pharmaceutical manufacturers, has already been announced by the Chemical Division of the Civilian Production Administration. The participating firms which constitute the Streptomycin Producers Advisory Committee of the CPA are Abbott Laboratories, Commercial Solvents Corporation, Charles Pfizer and Company, E. R. Squibb and Sons, Eli Lilly and Company, Heyden Chemical Corporation, Merck and Company, Parke, Davis and Company, Schenley Laboratories, Inc., The Upjohn Company, and Wyeth, Inc.

Dr. Keefer, who headed the clinical investigation of penicillin, will be in charge of the similar program on streptomycin and will submit recommendations, together with a report on the results. The CPA has announced that there will be no commercial distribution of streptomycin at this time, nor will the producers supply the drug directly for civilian requests. Physicians have been asked not to submit requests for streptomycin if the cases are susceptible to the action of the sulfonamides, penicillin and other therapeutic agents.

The production of streptomycin, which was approximately 3,000 grams last September, was expected to have increased to nearly 27,000 grams in March. A companion drug to penicillin, streptomycin is produced in a similar manner, by fermentation and chemical extraction, and, like penicillin, requires carefully controlled conditions of temperature, air and sterility. It is expected to prove a valuable supplement in cases where infections do not respond to penicillin treatment, but studies have not yet advanced to the point where the methods of administration or the amenable diseases are definitely known.

SCABIES

Scabies is always with us, but right now it is much more prevalent than usual. There are perhaps ten times as many cases as usual in Washington.

Doctors in general are urged to keep this disease in mind. It is embarrassing to the dermatologist to see case after case of scabies that has been treated for "nerves," or "acidosis," and given everything from calcium injections to penicillin for several months, and then have the patient well in a week with proper treatment for scabies. It is difficult to explain such a situation to the patient.

Remember that the commonest cause of generalized itching is scabies, and if more than one person in a household is affected, scabies is the cause in 99 per cent of the cases.

Keep scabies in mind.

COMMITTEE ON PUBLIC HEALTH

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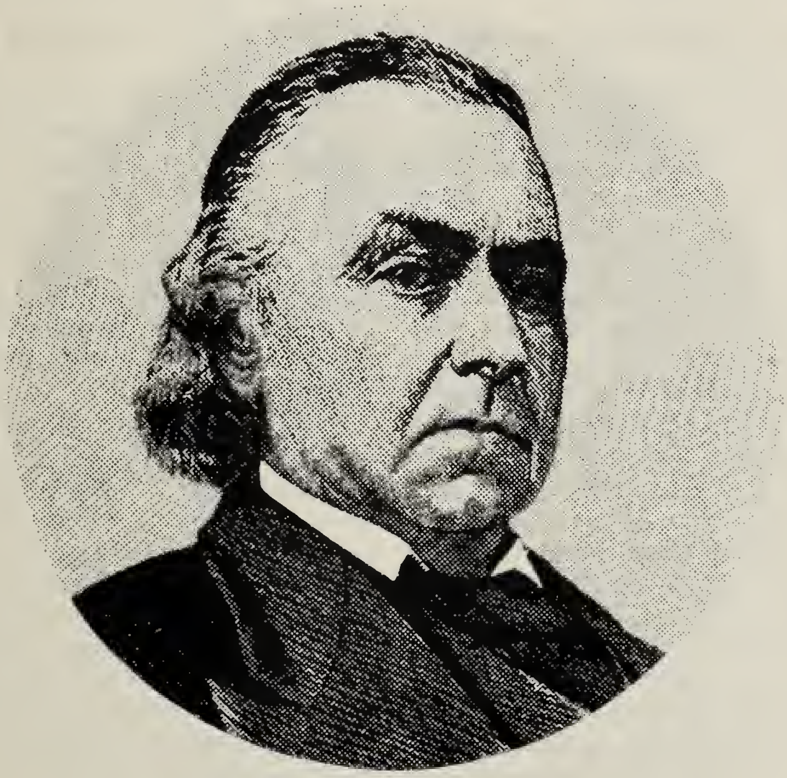
MEETINGS

Wednesday, May 1
ANNUAL BUSINESS MEETING

Wednesday, May 8
Speakers and subjects to be announced.

Wednesday, May 15
Speakers and subjects to be announced.



THOMAS MILLER, M.D.

Dr. Thomas Miller is entitled to a prominent place in Washington's medical history if for no other reason than that he originated the movement to establish a system of registration of births and deaths in the District of Columbia and was active in securing the establishment of St. Elizabeths Hospital.

Born February 18, 1806, at Port Royal, Virginia, he was educated at Washington Seminary and received his medical degree from the University of Pennsylvania in 1829. After his graduation he practiced in Washington. In 1830 he and six other physicians formed the Washington Medical Institute for the instruction of students.

Dr. Miller was one of the founders of the Medical Association of the District of Columbia, organized in 1833. He became its President in 1873. From 1839 to 1859 he was Professor of Anatomy in the Medical Department of Columbian College. He was also first President of the Pathological Society of Washington, attending surgeon at the Washington Infirmary, and consulting physician to Providence and Children's Hospitals.

Active in civic affairs, he was long a member of the Board of Aldermen. He was President of the Board of Health of the District of Columbia from 1846 to 1855.

Dr. Miller died in Washington on September 20, 1873.

Military Affairs

MEMBERS OF MEDICAL SOCIETY RECEIVE SELECTIVE SERVICE AWARDS

Five years ago when volunteers from the Medical Society of the District of Columbia and from other professional organizations were sought who would donate their talents in behalf of their country through the office of Selective Service, no one of them, it is certain, could have foreseen that such service would ever be recognized beyond his own knowledge and satisfaction of a job well done. However, on the evening of February 14, in the Interdepartmental Auditorium of the Department of Labor, at impressive ceremonies befitting the occasion, the Congressional Certificate of Merit and Selective Service Medal were awarded to 539 draft board officials who had served for more than two years on draft boards, examining boards, Boards of Appeal, advisory boards, and in other capacities through the organization known as the Selective Service System for the District of Columbia.

Genial William E. Leahy, District Director of Selective Service, presided. Following a program of music by the Metropolitan Police Band, the National Guard of Honor of the American Legion advanced colors, a ceremony which added a proper military note to the occasion. Rev. David V. McCauley, S. J., Dean of the School of Medicine of Georgetown University, opened with invocation. Mr. Leahy gave a brief account of the reasons for the ceremonies and paid eloquent tribute to those who had served on the home front through the war years. He spoke of the long hours of labor donated liberally and without compensation nor with any thought of reward.

Mr. Leahy then introduced a number of honored and distinguished guests, including Secretary of War Robert P. Patterson and Secretary of the Navy James V. Forrestal, both of whom responded in a few laudatory phrases. Mr. Forrestal mentioned the universal acceptance "without cavil and without rancor" of the decisions made by these Boards as the highest tribute that could be paid them for the work done. Mr. Patterson likewise expressed his deep gratitude and admiration for the work performed. Greetings from Major General Lewis G. Hershey, the Director of Selective Service, who was unable to be present, were delivered by Colonel Daniel Omer. Colonel Omer was generous in his praise of the work done by Mr. Leahy and, in behalf of General Hershey, pinned on him the Selective Service medal. Mr. Leahy responded graciously and modestly.

John Russell Young, President of the D. C. Board of Commissioners, was then introduced. Mr. Young stated that "during those years that you served I have never received one single letter or word of complaint about any Board." Other dignitaries present were Brigadier General Albert L. Cox, first Director of Selective Service in the District of Columbia, Brigadier General Robert N. Young, Commanding Officer of the Military District of Washington, Brigadier General Gordon Young, Engineer Commissioner for the District of Columbia, and Superintendent of Police Harvey Callahan.

Mr. Leahy read a section of the law which was passed on July 2, 1945, authorizing a certificate and medal for "service of more than two years" performed "voluntarily and without compensation" through the administration of Selective Service. The medal bears the inscription, "Awarded in the name of the Congress of the United States for faithful and loyal service."

Award of medals and certificates was made by Commissioner Young, first to widows and relatives of deceased board members. Wives of physicians so honored were Mmes. William T. Davis, E. R. Gookin, Henry T. Miller, Lyman B. Tibbetts and Richard F. Tobin. Other relatives accepted for Drs. Fred Repetti and William A. Mess.

Following is the Selective Service Honor Roll of the Medical Society of the District of Columbia.

Local Board Member

Irving A. Tennyson

Boards of Appeal

James A. Gannon
W. Cabell Moore

Local Board Examining Physicians

John N. Andrews
William P. Argy
Charles G. Aronstein
Garnet W. Ault
John M. Baber
William M. Ballinger
Joseph J. Bateman
Samuel Benjamin
Gregg C. Birdsall
Andrew K. Bowie
John E. Bowman
Charles J. Bowne
James W. Braden
Jeter C. Bradley
Irving Burka
Martin L. Cannon
Charles T. Carroll
Hill Carter
Philip A. Caulfield
William H. Clements
H. Eugene Cole
Thomas F. Collins
H. Lynn Colvin
Rush W. Conklin
Linn F. Cooper
Robert U. Cooper
Oliver C. Cox
Cyrus R. Creveling
Edwin S. Crisp
Cyrus W. Culver
J. B. Gregg Custis
Henry L. Darner
Edward Y. Davidson
Richard E. deButts
William DeKleine
Philip A. Degnan
Eugene deSavitsch
Samuel Dessoff
John V. Dolan
Harry F. Dowling
Leo W. Dufault
Richard E. Dunkley
Paul Eanet
Hugo Einstein
Herman Eisenberg
John H. Elvin
George I. Eppard
Clarence J. Fernald
Melville B. Fischer
Frederick C. Fishback
Eugene A. Forcione
I. Phillips Frohman
Leo B. Gaffney
Herbert S. Gates
Fred A. J. Geier
Benjamin Golden
Earl W. Graeff
Bernard L. Hardin
Robert H. Harmon
Lester Wilbur Harris
Robert Havell
Clayton Hawfield
James Hawfield
A. Fife Heath
Valentine M. Hess
Emil J. C. Hildenbrand
Russell K. Hollingsworth
Robert R. Hottel
George R. Huffman
Hugh H. Hussey
Simon R. Karpeles
Sollie Katzman
Thomas F. Keliher
Clapham P. King
Lewis A. Klein
Alan F. Kreglow
Jerome J. Krick
William C. Lambert
Allan E. Lee
Bernard W. Leonard
Alexander C. Leonardo
Louis P. Levitt
Arthur H. Lewis
Harry S. Lewis
William E. Long
Henry M. Lowden
William F. Luckett
Robert E. Maher
Benjamin Manchester
John B. Marbury
Emmett H. Markwood
Wilbur W. Martin
Herbert E. Martyn
Stephen A. McCarthy
Frank M. McChesney
Robert Sterling McGrath
Joseph J. McHale
Charles E. McNamara
Arnold McNitt
Richard J. McNulty
Beveridge Miller
John E. Morris
W. Ross Morris
Christopher J. Murphy
Walter K. Myers
Benjamin Newhouse
Howard E. Newman
Gilbert Ottenberg
R. Massie Page
Henry L. Peckham, Jr.
Glen Pincock
Alec A. Preece
Milton H. Prosperi
Maurice Protas
William G. Puryear
Edgar E. Quayle
Gilbert B. Rude
Ignatius Rutkoski
Harry Sacks
Aaron S. Schwartzman
John U. Schwarzmann, Jr.
Francis T. Sharpe
Richard F. Shaw
S. Hazen Shea
John A. Simpson
William B. Sims
Howard L. Smith
Harry A. Spigel
Richard H. Spire
William J. Stanton
Erwin Steinman
Leland E. Stevenson
Edward J. Stieglitz
Howard F. Strine
Richard T. Sullivan
X. Charles Suraci
Paul N. Taylor
Thomas C. Thompson
Aloysius W. Valentine
Stephen F. Verges
Willard B. Walters
John W. Warner
James W. Watts
H. Blacker Weinberg
R. Lomax Wells
Fred Y. Williamson
Harry Zehner
Samuel Zola

Medical Advisory Board Physicians

J. Gordon Bell
Norvell Belt
Carl Berg
Sterling Bockoven
Richmond C. A. Brooks
Irving Brotman
Caryl Burbank
Arthur C. Christie
William M. Clopton
Fred O. Coe
J. Lloyd Collins†
P. S. Constantinople
Robert F. Costello
Frank D. Costenbader
A. Barklie Coulter

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† Deceased.

Ronald A. Cox
Edward J. Cummings
Harry F. Davies
David Davis
Richard L. DeSaussure
Horatio N. Dorman
W. LeRoy Dunn
Lewis C. Ecker
Thomas A. Egan
Frank J. Eichenlaub
Clayton B. Ethridge
Andrew B. Evans
James M. Fadeley
Russell J. Fields
Aubrey D. Fischer
Raymond K. Foxwell
Leslie H. French
G. Roland Gable
Joseph L. Gilbert
G. Bache Gill
John H. Gilligan
E. Leonard Goodman
Edgar D. Griffin
Ernest E. Hadley
Custis Lee Hall
Frank A. Hornaday
Hugh O. House
LeRoy Hyde
Don R. Johnson
Robert A. Keilty
Edward B. Kelly
Joseph V. Kennedy
Michael Kennedy
Ralph M. LeComte
Janvier W. Lindsay
John Robert Lloyd
Samuel Luber
Samuel A. Machlis
G. Haven Mankin
William B. Marbury
Lawrence B. McCaleb
Hector C. McKnew
Edgar M. McPeak
Daniel B. Moffett
Frederic A. Moretti
William A. Morgan
Julius S. Neviaser
Joel N. Novick
Edward M. O'Brien
John M. Orem
Ralph S. Pendexter
Julius J. Radice
John A. Reed
Edward Hiram Reede
John A. Reisinger
Frederick A. Reuter
E. Clarence Rice
Fred R. Sanderson
LeRoy L. Sawyer
Norman P. Scala
Ernest Sheppard
Samuel A. Silk
William C. Sparks
W. Calhoun Stirling
John A. Talbot
Eugene A. Taylor
A. Contee Thompson
John H. Trinder
Homer King Vann
Allan E. Walker, Jr.
J. Ogle Warfield, Jr.
Charles S. White
Inez Edith Wilber
Richard W. Wilkinson
Albert Winer
Alvin E. W. Wode

Following presentation of awards, the program closed with a benediction by the Rev. Charles T. Warner of St. Alban's Church and the retirement of colors.

Present to welcome guests at the meeting was Colonel A. Clagett Gray, who is State Medical Officer of Selective Service for the District of Columbia.

Another ceremony will be held, probably in April, for the award of additional medals and certificates to other members of the Medical Society who were called to active military duty with the armed services before they had completed the two-year period of service required for the initial award, but who had served with the Selective Service System for a substantial period. Other awards of medals and certificates will be made to those who have made a substantial contribution to the success of the Selective Service System in the District of Columbia even though they were not regularly appointed to local or advisory boards.

WOMAN'S AUXILIARY NOTES

The Woman's Auxiliary to the Medical Society of the District of Columbia meets the second Wednesday of the month at 11:00 a.m. in the library of the Medical Society's building, 1718 M Street, N.W. The business meeting is followed by a program and luncheon. Mrs. Edgar E. Quayle, Program Chairman, and her Committee are to be congratulated for the excellent speakers and muscial programs we have had the pleasure of hearing. Luncheon is served by the House Committee, Mrs. Richard E. Dunkley, Chairman.

Proceeds of the last two performances of "A Portrait of George Sand," Mrs. James Souby's play, at the Arts Club were turned over to the Woman's Auxiliary. Taking the lead as the amazing and romantic George Sand was Miss Marian Norris, daughter of Dr. and Mrs. Leo Brison Norris, while the Countess d'Agoult was played by Mrs. John Amussen, daughter of Dr. and Mrs. Fred R. Sanderson. Both were excellent in their parts and those who had the pleasure of seeing the play enjoyed the evening's entertainment. Mrs. Norris, Chairman, and members of the Ways and Means Committee arranged this benefit. We are indeed grateful to all who helped in making this project a success.

Mrs. William J. B. Orr
Publicity Chairman

News and Personals

Hotel accommodations for those who wish to attend the **American Medical Association Convention** in San Francisco, July 1–6, 1946, should be made now by writing to Dr. M. Laurence Montgomery, Chairman, Subcommittee on Hotels, AMA Convention, Room 200 Civic Auditorium, San Francisco 2, Calif.

The American College of Chest Physicians announces that the next oral and written examinations for Fellowship in the College will be held in San Francisco on June 29, 1946. Those who wish to take the examination should communicate with the Executive Secretary, American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

The twelfth Annual Meeting of the College will be held at the Sir Francis Drake Hotel, San Francisco, June 29–30, July 1–2.

The Bureau of Medicine and Surgery, Navy Department, will convene Boards of Medical Examiners and Supervisory Naval Examining Boards during the period May 6 to 10, 1946, at 29 continental U. S. Naval Hospitals for the purpose of conducting physical and professional examinations of eligible candidates for appointment to the grades of Assistant Surgeon and Acting Assistant Surgeon in the U. S. Navy. Nearby cities where the examinations will be given are Annapolis, Bainbridge, and Bethesda, Maryland.

Complete information, application forms for appointment, and other data may be secured by writing the Bureau of Medicine and Surgery, Navy Department, Washington 25, D. C.

The book publishing firm of **W. W. Norton and Company** announces that they are again inviting manuscripts for submission to be considered for the **Norton Medical Award** of $3,500 offered to encourage the writing of books on medicine and the medical profession for the layman. The first such award was made to Dr. Carl Binger for his book, "The Doctor's Job," published last spring. Announcement will be made shortly of the winning book for 1946.

CALENDAR OF MEETINGS

March 1	Service Physicians
March 4	Nominating Committee
March 5	Nominating Committee
March 6	Business Meeting of Society
March 8	Subcommittee on Maternal Welfare
March 14	Committee on Public Health
March 15	Board of Censors
March 19	Subcommittee on Mental Health
March 20	Scientific Meeting of Society
March 22	Committee on Public Policy
March 25	Executive Board Service Physicians
March 26	Committee on Service Physicians
March 27	Scientific Meeting of Society
March 29	Interprofessional Conference Committee on Arrangements, Annual Scientific Assembly

Closing date for submission of manuscripts for the 1947 award is November 1, 1946. All particulars relating to requirements and terms may be had by addressing W. W. Norton and Company, Inc., 70 Fifth Avenue, New York 11, N. Y.

The Medical and Chirurgical Faculty of Maryland cordially extends an invitation to members of the Medical Society of the District of Columbia to attend its annual meeting, beginning at 9 a.m., April 23, and continuing until 11 p.m., April 24. The major portion of the program will be given at the Belvedere Hotel, with the final general meeting in the Faculty's own building at 1211 Cathedral Street, Baltimore.

The Clinico-Pathological Society met March 5 at the home of Dr. W. B. Marbury. Two papers were presented: "Potassium Thiocyanate in the Treatment of Arterial Hypertension," Dr. Matthew White Perry; "Chest Tumors and Routine Examination," Dr. Janvier W. Lindsay.

The annual meeting of the Society was held at the Chevy Chase Club, April 9. Brigadier General Leon Alexander Fox, U.S.A., retired, spoke on the subject, "Teaching of Preventive Medicine in the Medical Schools."

More than 60 members of the **Hippocrates-Galen Society** were entertained February 7 at the home of Dr. George Trible. Dr. Brian Blades, Professor of Surgery at George Washington University School of Medicine, gave an address on the subject, "Mediastinal Tumors." The paper was discussed by Dr. Edgar Davis. Dr. W. Ross Morris, President of the Society, presided.

The meeting of the Society, March 7, was held at the Kennedy-Warren Apartments. Dr. George T. Sharpe discussed "Cancer of the Uterus," and Dr. Walter K. Myers gave a case report on "Gonococcal Endocarditis Cured by Penicillin Therapy." Participating in the discussion which followed were Drs. Ralph M. Caulk, W. LeRoy Dunn, William M. Ballinger, Emil H. Bauersfeld, and W. Ross Morris.

The Washington, D. C. Ophthalmological Society met March 4 in the Medical Society's building. Two papers were read at this meeting, one on "Removal of Cataract in the Presence of Fluid Vitreous" by Dr. Daniel B. Kirby of New York, and the second by Dr. Ernest Sheppard on "Simple Technique of Low Magnification Gonioscopy." On display was an exhibit of gonioscopy drawings which had been arranged by Miss Lorraine Bean.

The regular meeting of the **Medical Society of St. Elizabeths Hospital** was held on February 28. Dr. Nolan D. C. Lewis, Director of the New York State Psychiatric Institute and Psychiatric Adviser to the International War Crimes Tribunal, spoke on "Impressions of Psychological Factors in the Nazi Ideology."

The annual scientific session of the Society will be held at the Hospital on April 26 and 27. A varied and timely medical and psychiatric program will be presented. Members of the medical and allied professions are cordially invited to attend.

Guest speaker at the **George Washington University Medical Society**, March 23, was Dr. Henry H. Turner, Associate Professor of Medicine, University of Oklahoma School of Medicine, and Past President of the American Therapeutic Society. Dr. Turner reported results of his eight years' experience in "The Clinical Use of Testosterone Propionate."

Howard University School of Medicine has accepted an invitation to join the **Deans' Committee for Mount Alto Hospital,** which opens the way for Negro physicians to be appointed to Mount Alto as consultants and for graduates of Howard Medical School to be selected as resident physicians at this hospital. The Deans' Committee was established last January by the Veterans' Administration to prescribe medical standards, judge professional qualifications of the staff, and select resident physicians and consultants for Mount Alto Hospital. In addition to Dr. Walter A. Bloedorn, Dean of George Washington University School of Medicine and Chairman of the Committee, and the Rev. David V. McCauley, S. J., Dean of Georgetown University School of Medicine, the Committee will now include Dr. John W. Lawlah, Dean of Howard University School of Medicine.

Subsequent to publication of the list of part-time consultants in the March issue of the MEDICAL ANNALS, five additional consultants, two attending physicians, and two resident physicians have been appointed to the staff of Mount Alto with the approval of the Deans' Committee. The names of the consultants and the fields of medicine they represent are:

Clinical Medicine: Dr. Roger M. Choisser
Dermatology: Dr. Frank J. Eichenlaub
Gynecology: Dr. Jerome F. Crowley
Internal Medicine: Drs. William J. Mallory and Lewis C. Ecker

Attending physicians appointed were Dr. William T. Gibb (gastroenterology) and Dr. William S. McCune (general surgery).

Selected as the first full-time resident physicians by the new Deans' Committee were Dr. William M. Fox (radiology) and Dr. Andrew J. Brennan (general medicine).

According to information released by the **American College of Surgeons,** five hospitals in the District of Columbia are approved by them for graduate training in surgery and/or a surgical specialty. They are Central Dispensary and Emergency, Freedmen's, Gallinger Municipal, Georgetown University and Providence.

Eleven hospitals have been approved for training interns by the **Council on Medical Education and Hospitals of the American Medical Association.** They include the five mentioned above and Doctors, Garfield Memorial, George Washington University, Providence, St. Elizabeths and Sibley Memorial Hospitals, and Washington Sanitarium and Hospital.

Selective Service Medal being presented by GENERAL LEWIS B. HERSHEY to DR. HENRY C. MACATEE

Approved for residencies or fellowships by the Council on Medical Education and Hospitals of the AMA are Central Dispensary and Emergency, Children's, Columbia Hospital for Women, Episcopal Eye, Ear and Throat, Freedmen's, Gallinger, Garfield, Georgetown University, George Washington University, Providence, St. Elizabeths and Sibley.

The List of Approved Hospitals, as published in the December *Bulletin of the American College of Surgeons*, does not include the U. S. Government hospitals (Army, Navy, Veterans' Administration and Public Health Service) inasmuch as the survey of these institutions was not completed at the time this publication went to press. A supplement will list the Government hospitals which are approved by the American College of Surgeons.

Selective Service Medals were presented at special ceremonies in the Interdepartmental Auditorium of the Department of Labor, March 19, to 50 men who helped formulate and administer the Selective Training and Service Act of 1940 without compensation. Major General Lewis B. Hershey, Selective Service Director, presented the awards. Among members of the Medical Society of the District of Columbia who were present to receive the medals and certificates were Drs. Winfred Overholser, Henry C. Macatee, Albert N. Baggs, Roscoe W. Hall, and Theodore Wiprud, Secretary of the Society. Mr. William E. Leahy received the certificate and medal for Dr. F. X. McGovern, who was out of the city and therefore unable to attend the ceremonies.

Washington's first diagnostic clinic to be operated in conjunction with a hospital is planned as a part of the new **George Washington University Hospital** to be completed next year. The proposed clinic, according to Dr. Walter A. Bloedorn, Dean of the School of Medicine, will provide complete diagnostic services at reasonable cost to patients limited to the moderate income group, defined by Dr. Bloedorn as $3,500 or less. The clinic will be staffed by the Medical School's faculty in all the major departments of medicine and surgery. It will accept only patients referred by the patient's private physician, and will give no treatment. A standard fee will be charged for this service, perhaps as low as $25. After diagnostic examination a complete report accompanied if advisable by treatment recommendations, will be referred back to the patient's doctor.

The 96th graduation exercises of **Georgetown University School of Medicine,** March 17, marked the formal closing of the Army Specialized Training Program and the Navy V-12 Program which began in 1943 and has continued during the war years. Francis Cardinal Spellman, Archbishop of New York, addressed the 81 graduates. The new school year will begin September 16.

The Executive Board, at its meeting February 25, took cognizance of the fact that the Committee on Medical Service, which was organized primarily to meet emergencies which might arise during the War, had long been inactive. The Board decided to discontinue the Committee as of the date of meeting.

For chairmen of the various Subcommittees for the 17th Annual Scientific Assembly President William Earl Clark submitted the following names which were approved by the Executive Board:

Attendance—Dr. Luther H. Snyder
Program—Dr. Robert J. Coffey
Scientific Exhibits—Dr. Emil J. B. Hildenbrand
Motion Pictures—Dr. Alan F. Kreglow
Social Affairs—Dr. Herbert P. Ramsey
Finance—Dr. Harold M. Hobart
Public Meeting—Dr. Arnold McNitt
War Souvenirs Exhibit—Dr. J. Lawn Thompson, Jr.
Women Physicians—Dr. Helen Gladys Kain

A new committee to be known as the Advisory Committee for the 17th Annual Scientific Assembly was also appointed. The members selected were Dr. Oscar B. Hunter; Dr. Brian Blades, Consultant in Thoracic Surgery to the Surgeon General, War Department; Dr. Paul F. Dickens, State Director of Procurement and Assignment for the District of Columbia; Commodore Alphonse McMahon, Chief of Training Branch of Professional Division, Bureau of Medicine and Surgery; and Dr. Warren F. Draper, Deputy Surgeon General, U. S. Public Health Service.

The Bureau of Mental Hygiene of the D. C. Health Department opened a **Mental Hygiene Clinic for Adults,** March 5. The new Clinic will undertake to give psychiatric examination and treatment to adult patients, other than alcoholics, who are unable to pay private physicians for such services. It will be located in the New Municipal Building, 300 Indiana Avenue, Northwest, Room 6025; telephone National 6000, Extension 2194.

Patients may apply directly to the Bureau or they may be referred by any public or private agency. In case of referral by a physician, the latter should submit a report on physical examination and history.

After the first interview with the patient, the psychiatrist will decide whether or not he is suitable for treatment. The psychiatrist will then notify the referring agency or physician of his opinion and his decision as to treatment. Findings and diagnoses will be kept strictly confidential and will not be imparted to anyone without the patient's consent. The psychiatrist will give follow-up reports at reasonable intervals and notice about termination of treatment to the referring agency or physician.

Dr. Leopold E. Wexberg is Director of the Bureau of Mental Hygiene.

The first number of a new journal has just made its appearance in the Medical Society's office, entitled *Journal of the History of Medicine and Allied Sciences*. The journal, to be published quarterly by Henry Schuman, 20 East 70th Street, New York 21, N. Y., will be devoted "to the prompt publication of work relating to all aspects of the history of medicine, public health, dentistry, nursing, pharmacy, veterinary medicine and the various sciences that impinge on medicine."

Dr. G. Foard McGinnes, Medical Director of the American Red Cross, has been named Vice Chairman in charge of the newly established Office for Health Services. The new office groups together all Red Cross Services relating to health and medical activities, i.e., the office of the medical director, the nursing, nutrition and disaster medical services, and first aid, water safety and accident prevention. In addition to being responsible for Red Cross health and medical activities, Dr. McGinnes will maintain liaison with the offices of the Surgeon General of the Army, Navy, and Public Health Service, and with other medical and health agencies.

The Doctors Group subscribing to benefits under **Group Hospitalization, Inc.,** now numbers 457. The books will be open again to new subscribers during the month of August.

The D. C. Dietetic Association has just issued a new quarterly *Bulletin*, the first copy appearing in February.

Dr. Oscar B. Hunter was appointed Adjunct Professor of Medicine at Georgetown University School of Medicine, in December, 1945.

At the **25th Anniversary Meeting of the Washington Society for the Hard of Hearing,** February 15, Vice Admiral Ross T. McIntire, Surgeon General of the Navy, was the principal speaker. His talk was entitled, "Rehabilitation Program of the Navy."

Dr. James N. Greear, Jr., was among the guests present at a conference of civilian doctors and Army Medical Corps officers, all specialists in ophthalmology and related plastic surgery, which was held February 9 and 10 at Valley Forge General Hospital, Phoenixville, Pa. Dr. Greear was formerly Chief of the Hospital's Eye, Ear, Nose and Throat Section.

Dr. Oscar B. Hunter attended a number of meetings while in Chicago the week of March 2–9. He participated in the Postgraduate Seminar in Clinical Pathology which was held under the auspices of the American Society of Clinical Pathologists, March 2, 3, and 4. During the week he was in conference with the Committee on Tests for Alcoholic Intoxication of the National Safety Council. On March 8 and 9 he attended the meetings of the American Society of Pathologists and Bacteriologists, which were held in the Department of Pathology of the University of Chicago School of Medicine.

Dr. Hunter was accompanied by his son, **Dr. Oscar B. Hunter, Jr.,** who also attended the Seminar and scientific meetings and took the examinations for the specialty boards in pathology.

The first Medical Section Meeting of the **Metropolitan Washington Tuberculosis Conference** was held on February 28 in the Arlington County Health Center. The Chairman, Dr. Leroy R. Allen, presided. Dr. R. G. Beachley, Health Officer for Arlington County, Va., greeted the guests. Following a progress report by Dr. Daniel Leo Finucane, President of the Conference, Dr. Dean Cole of Richmond, Virginia, addressed the members on "The Clinical Evaluation of Minimal and Incipient Tuberculosis."

Dr. William S. Miller, who recently returned from service in the Army, is enrolling for postgraduate work in internal medicine at the Pratt Diagnostic Hospital and the Massachusetts General Hospital in Boston. He will be away from Washington for several months.

The D. C. Dental Society will resume its **Five State Clinic** this year with meetings at the Statler Hotel, May 24–27.

Dr. Walter R. Stokes addressed a meeting of the Planned Parenthood Association, February 25. **Dr. James Leake** of the U. S. Public Health Service also appeared on the program. He discussed his recent tour of Europe as medical adviser to Herbert Lehman, head of United Nations Relief and Rehabilitation Administration.

Miss Lucile Petry, head of the U. S. Cadet Nurse Corps, has been appointed chief of the new division of nursing of the **U. S. Public Health Service.** One of the first nurses to be commissioned in the U.S.P.H.S., Miss Petry will hold the rank of Nurse Director, which is equivalent to that of Captain in the Navy. She has been with the Public Health Service since 1941 and was named Director of Nurses' Training two years ago.

This division, which now includes administration of the Cadet Nurse Corps, will coördinate all nursing activities of the Public Health Service. Miss Petry, a graduate of Johns Hopkins School of Nursing and Teachers College of Columbia University, was formerly Dean of the School of Nursing, Cornell University.

Since several back issues of the journal, *Surgery, Gynecology and Obstetrics*, have been depleted, the office of The Surgical Publishing Company of Chicago, 54 East Erie Street, Chicago 11, Illinois, is willing to pay 75 cents each for any of the following copies returned to them:

1943—February, March, April, May, November, December
1944—January, February, March, September
1945—January, February, May, June, July, August, October

The journals may be returned by second-class mail or parcel post, whichever rate is lower. Cost of postage will be refunded. The text matter, of course, must be complete and not mutilated or defaced in any way.

Copies of the four lectures which were presented at the **Postgraduate Course on Psychosomatic Medicine** during May, 1944 are available upon request at the Society's office, 1718 M Street, N. W., telephone District 3111. The lecturers for this course were Drs. Edward Weiss, Joseph Yaskin, Foster Kennedy and George W. Kosmak.

The Workmen's Compensation Fee Schedule will soon be available at the Society's office in printed form. Copies may be secured by calling District 3111.

Dr. Wallace M. Yater has been appointed civilian consultant to the Army Institute of Pathology. He will continue in private practice.

Dr. Read N. Calvert participated in the two-day Sectional Meeting of the American College of Surgeons which was held recently in Pittsburgh. His topic for the morning session, March 12, was "Two Stage Operation for Diverticulum of the Esophagus."

Among the speakers at the Hospital Conference was **O. K. Fike,** Director of the Miami Valley Hospital. Mr. Fike was formerly Director of Doctors Hospital in Washington.

Theodore Wiprud lectured to senior students of Howard University School of Medicine, March 8 and 14, on doctors' financial records and the proper handling of patients' accounts.

On April 1 he appeared before the Prince Georges County Medical Society to discuss prepayment medical plans.

NOTICE TO PRIVATE PHYSICIANS:

To facilitate admissions of tuberculous patients to District sanatoria, the Health Department requests that physicians desiring hospitalization of tuberculous patients first clear with the Health Department's Bureau for Tuberculosis, Dr. A. Barklie Coulter, Director, National 6000, Extension 2140, for such admissions. However, for the admission of emergency cases (hemorrhage) authorization may be obtained after 5 p. m. and on holidays by calling Gallinger Hospital, telephone Atlantic 0600.

GEORGE C. RUHLAND, M.D.
Health Officer, District of Columbia

The Society's office will appreciate receiving copies of the January and February, 1946, issues of the MEDICAL ANNALS from members who have finished with them. More requests have been received for these copies than can be filled from the supply on hand.

Dr. William H. Jenkins described the fenestration operation for otosclerosis before the parent training group of the Washington Society for the Hard of Hearing, March 15.

MEMBERSHIP

The following applicants for membership were duly elected to membership at the meeting of the Executive Board, February 25, 1946, in accord with Amendment XI, Section 2, of the Constitution and By-laws of the Society:

Active Members

Arnold Albert, 2713 Wisconsin Avenue, N.W.
E. Herbert Bauersfeld, 17 Dupont Circle
Walter H. Gerwig, Jr., 1835 Eye Street, N.W.
Naomi Kaplan, 1328 Eye Street, N.W.
Irvin S. Miller, 1222 Monroe Street, N.E.
R. Bretney Miller, 1834 Eye Street, N.W.
Michael M. Miller, 1806 23rd Street, S.E.
Harold Stevens, 525 Mellon Street, S.E.
Leopold E. Wexberg, Bureau of Mental Hygiene, D. C. Health Department

Associate Members

nk S. Bacon, 2650 Wisconsin Avenue, N.W.
ldon A. Price, 3260 Wilson Blvd., Arlington, Va.
uel J. N. Sugar, 4218 28th Street, Mt. Rainier, Md.
and H. White, 8416 Georgia Avenue, Silver Spring, Md.

The following applicants for membership were y elected to membership at the meeting of the ecutive Board, March 25, 1946, in accord with endment XI, Section 2, of the Constitution and -laws of the Society:

Active Members

nuel M. Becker, 2028—16th Street, N. W.
nard S. Berman, 1710 Rhode Island Avenue, N. W.
lliam J. G. Davis, 3601 Lowell Street, N. W.
rcel J. Foret, 3511 Davenport Street, N. W.
nand B. Gordon, 2812 Connecticut Avenue, N. W.
e Grollman, 2012 R Street, N. W.
nuel A. Hillman, 249 Concord Avenue, N. W.
ar B. Hunter, Jr., 1835 Eye Street, N. W.
nard Katzen, 3550 Minnesota Avenue, S. E.
el Kessler, 2500—41st Street, N. W.
arles E. Law, 1835 Eye Street, N. W.
arles D. Lenhoff, 903—16th Street, N. W.
k L. Levine, 900—17th Street, N. W.
gene G. Lipow, 903—16th Street, N. W.
rold F. McCann, 3100—20th Street, N. E.
J. Russell McNitt, 1801 Eye Street, N. W.
ney Olansky, Gallinger Hospital
n H. Peacock, 2032 Belmont Road, N. W.
n C. Sherburne, 5 East Melbourne Avenue, Silver Spring, Md.
drew L. Smith, 200 Maryland Avenue, N. E.
Ross Taggart, 5327—2nd Street, N. W.

Associate Members

mer J. Brown, 45 Carroll Avenue, Takoma Park, Md.
olph E. Drexel, 114 S. Asaph Street, Alexandria, Va.
ma Hughes, Washington Sanitarium, Takoma Park, Md.

The following applicants for membership will be ted on at the meeting of the Executive Board, ril 22, 1946:

Active Members

rgaret Elizabeth Callan, George Washington University—941
lliam Nason Heffner, Georgetown University—1940
yton Howard Hixson, George Washington University—927
l Bernard Hoberman, George Washington University—943
mille Roger Kurtz, Jefferson Medical College—1939
muel Dennis Loube, George Washington University—1943
John Whitney Nesbitt, Northwestern University—1934
Thomas J. Pekin, Loyola University—1931
Leonard T. Peterson, University of Minnesota—1932
John Otto Schreiber, Georgetown University—1939
Joseph John Tamasi, Georgetown University—1938
William Lynn Wingfield, Medical College of Virginia—1937

The following applicants for membership will be voted on at the meeting of the Executive Board, May 27, 1946:

For Active Membership

Lester L. Burtnick, University of Maryland—1937
Eugene Francis Finnegan, Georgetown University—1940
Andrew Endre Fischer, M. kir. Tisza Istvan Tudomanyegyetem, Debrecen, Hungary—1933
James Quincy Gant, Medical College of Virginia—1935
William T. Lady, George Washington University—1938
John Alfred Norcross, George Washington University—1937
Lawrence Albert Rapee, George Washington University—1939
Katherine Kempner Rice, Johns Hopkins University—1941
Lee Bruner Snow, George Washington University—1940
Reuben Sorkin, Edinburgh School of Medicine—1938
Sherman Augustus Thomas, University of Arkansas—1939
George Tievsky, George Washington University—1943
Robert Burwell Nelson, Jr., University of Virginia—1936

For Associate Membership

Otis Rhanos Farley, Rush Medical College—1940
Greenville Burton Queen, Rush Medical College—1933

CORRESPONDENCE

New York, N. Y., March 11, 1946

The Observer
Medical Annals of the District of Columbia
Washington, D. C.

Dear Observer:

Enclosed is my resignation from the Society by reason of leaving Washington for New York, but I cannot take leave without a farewell note to you.

Your columns have again scored in my mind, this time with comments on Psychiatry Unaccepted (February 1946).

In six years of practice in Washington my referrals from physicians not psychiatrists were few, and in most cases did not progress to a satisfactory treatment situation. I have no complaint because I was always busy and had a waiting list. I think the trouble was that physicians used the psychiatrist as someone on whom to dump undesirable patients. This procedure will increase with return of physicians from the services, as there it was the habit to turn everything over to the psychiatrist for which no organic cause was found. This was in spite of the desirable medical principle that no psychiatric diagnosis be made solely on the basis of excluding organic illness.

Besides choosing patients more carefully for psychiatric referral, practitioners will also have to give some thought to the method of referral. It has been my experience and that of my colleagues that patients are referred in such a manner as tends to work against a successful outcome with the psychiatrist.

And, lastly, your point about psychiatry being in its infancy has certain implications. It implies, and this is unfortunately a fact, that psychiatrists are not able to be of aid in all cases of psychiatric disorder. I do not refer only to long standing psychoses, but also to the so-called psychosomatic disorders which are being more and more referred to psychiatry. This means that physicians in general, and their followers among patients will have to become more aware of this: that doctors are not able to cure everything that comes their way. There are some conditions for which we have no answer, in terms of practical treatment.

Let me say goodbye by expressing my appreciation for the way you use your columns to open up discussions rather than to close them off.

Yours sincerely,
Ralph M. Crowley, M.D.

ALEXANDER BERKELEY MOORE, M.D., F.A.C.P.

(1883–1946)

Dr. Alexander B. Moore, chief radiologist at Emergency Hospital for the past 16 years, died March 8, 1946, at Emergency Hospital following a week's illness.

Dr. Moore was a native Virginian, born at Aldie, in Loudoun County, November 8, 1883. He received his degree in medicine from the University of Virginia in 1907. From 1910 to 1929 he was roentgenologist at the Mayo Clinic, Rochester, attaining the position of senior consultant of the Section on Roentgenology. Since June 1929 he has been roentgenologist to Emergency Hospital, Washington, and associated in private practice with the firm of Groover, Christie and Merritt, with offices at 1835 Eye Street, N. W. He served overseas with the Medical Corps in World War I, with the rank of Captain.

Dr. Moore was a diplomate of the American Board of Radiology, and held membership in a number of scientific organizations. He was a Fellow of the American Medical Association, the American College of Physicians, and the American College of Radiology. He was Past President of the American Roentgen-Ray Society, and a member of the Radiological Society of North America, Inc., and the American Gastroenterological Association. He had been an Active Member of the Medical Society of the District of Columbia since 1931.

He was also a member of St. Mary's Episcopal Church, Arlington, Va., the Washington Golf and Country Club, and the Metropolitan Club.

Surviving are his wife, Mrs. Carolyn Watson Moore, who resides at their home at 3301 North Glebe Road, Arlington, Va.; two daughters, Mrs. Robert S. Beckham, Tarrytown, N. Y., and Miss Lucy Berkeley Moore; and a sister, Miss Anne Beverley Moore, of Georgetown, Delaware.

ALBERT PERKINS TIBBETS, M.D., F.A.C.S.

(1884–1946)

Dr. Albert P. Tibbets, well known otolaryngologist, died January 31, 1946, at his home, 131 Hesketh Street, Chevy Chase, Md., following a long illness. Before retiring from practice he had maintained his office at 1801 Eye Street, N.W.

Dr. Tibbets was born in Somersworth, New Hampshire, November 14, 1884, the son of William S. and Caroline Tibbets. After studying at Dartmouth College for three years he moved to Washington, completing his studies for a B. A. degree at George Washington University in 1907. He received his medical training at the same University, graduating from the School of Medicine in 1910. Postgraduate study in otolaryngology was pursued at Roosevelt Hospital, New York, during 1919, following which he served for a number of years on the staff of George Washington University School of Medicine as Assistant Professor of Otolaryngology and for 25 years on the staff of the Episcopal Eye, Ear and Throat Hospital.

He was a member of the District Naval Militia and when that organization was called into active service in April, 1917, he was assigned to the *U.S.S. Verus*. Subsequently he was attached to the naval transport *U.S.S. Matsonia*, on which he served the remainder of the war as senior medical officer with the rank of Lieutenant Commander. With the exception of service during World War I he practiced continuously in the District of Columbia for 35 years.

Dr. Tibbets was elected to Active membership in the Medical Society of the District of Columbia in 1912. He was a Fellow of the American Medical Association, a Fellow of the American College of Surgeons, a past President of the Washington Medical and Surgical Society, a member of the George Washington University Medical Society, and a diplomate of the American Board of Otolaryngology. He was also a member of the Military Order of the World Wars.

Besides his wife, Mrs. Katherine Herbert Tibbets, he is survived by two sons, Lt. Comdr. Richard H. Tibbets, U.S.N.R., Commander of the *U.S.S. Prentiss*, and William S. Tibbets, on duty with the Merchant Marines. He also leaves a sister, Miss Jane Tibbets, of New York, and a brother, William A. Tibbets, of Detroit.

AMY JEAN RULE, M.D.

(1870–1946)

Dr. Amy Jean Rule, a practicing physician in Washington since 1916, died January 29, 1946, at her residence, 1852 Columbia Road, N. W. She had been in ill health for a number of years.

Dr. Rule was a native of Jacksonville, Illinois, born June 15, 1870. She graduated from Garfield Hospital Training School for Nurses in 1896, after which she served as Superintendent of the National Training School for Girls for eight years. Upon deciding to study medicine, she enrolled in the Woman's Medical College of Philadelphia, graduating from that school in 1908. From 1908 to 1915 she served as resident physician at the State Hospital at Norristown, Pa. Returning to Washington in the fall of 1915, she began the private practice of medicine which was to continue until shortly before her death.

She was a Fellow of the American Medical Association, an Active Member of the Medical Society of the District of Columbia since 1916, and a member of the District Women's Medical Society. She also was affiliated with the Ruth Brewster Chapter, DAR, and the Mount Pleasant Chapter, Order of the Eastern Star. For more than 25 years she had served on the medical staff of the Masonic and Eastern Star Home.

She leaves a sister, Mrs. John R. T. Reeves of Washington, and two brothers, J. Arthur Rule of Arion, Iowa, and Chester A. Rule of Indianola, Iowa.

HARRY TEMPLAR GUSS, M.D.

(1859–1946)

Dr. Harry T. Guss, an Associate Member of the Medical Society of the District of Columbia, died January 19, 1946, in St. Petersburg, Florida, where he moved when he left Washington in 1938.

Dr. Guss, who was born in Gettysburg, Pennsylvania, May 14, 1859, graduated from Jefferson Medical College, Philadelphia, in 1886. For many years before his retirement he was employed in the Insurance Medical Section of the Veterans' Bureau. He had been a resident of the District of Columbia for almost 50 years.

His Associate membership in the Medical Society was continuous from 1924. He was also a member of the Washington Society of Oldest Inhabitants.

Surviving is his wife, Mrs. Ellen Guss, who resides at 772 Bayou Blvd., St. Petersburg, Florida.

CARL MICHEL, M.D.

(1890–1946)

Rear Admiral Carl Michel, Chief Medical Officer of the Coast Guard and Assistant Surgeon General of the United States Public Health Service, died January 3, 1946, at the Naval Medical Center, Bethesda, Md., following a cerebral hemorrhage which occurred the previous day at his home in the Westchester Apartments.

Admiral Michel was born in Chicago, May 4, 1890, and graduated from the University of Illinois in 1912. In 1914 he joined the Public Health Service. The following year he was detailed to the U. S. Coast Guard Academy at New London, Conn., as a medical officer, and in that capacity made several cruises on Coast Guard cutters. Following a tour of duty in Puerto Rico he was assigned to service with the Coast Guard at the outbreak of World War I and was commended for exceptional performance on the Coast Guard cutter *Itasca.* In July, 1940 he was appointed Chief Medical Officer of the Coast Guard and three years later was advanced to Assistant Surgeon General of the U. S. Public Health Service.

He became internationally known as an expert on control of plagues and epidemics and in establishing quarantine procedure. He fought contagious diseases in almost every section of the United States as well as in Puerto Rico and Mexico. While serving in Puerto Rico he was made a member of the Institute of Tropical Medicine and Hygiene, and for his work in eradicating yellow fever in Vera Cruz, Mexico, he was made Honorary Councilor of the Health of the Republic of Mexico. Dr. Michel was the first to call attention to the fact that airplanes sometimes carry mosquitoes and as a result inspection of airplanes began and a standard airplane quarantine system was organized in Miami, Florida.

Admiral Michel is survived by his wife, Mrs. Mary Field Michel; a daughter, Mrs. J. J. McClelland; two sons, Major John Michel, with the Army Engineers, and Carl Michel, Jr., recently discharged from the Coast Guard and now a student at the University of Virginia; and four brothers, Colonel Paul, Herman, Walter and Frederick Michel.

Myocardial Infarction in Negroes—Fitzgerald and Yater

(*Continued from page 159*)

Coronary arteriosclerotic heart disease must be considered in the differential diagnosis of all cases of anterior thoracic pain, sudden collapse, and congestive heart failure in Negroes not adequately explained by other causes.

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Children in Wartime—Dub

(*Continued from page 162*)

have been erected for some war industry communities. Acts of Congress have provided for better medical care for the families of servicemen. There is a decreasing maternal and infant mortality rate.

Yet, much is still to be done for the present and future of children. Tolerance must be developed, including racial and religious tolerance. It is to be hoped, for the security of the world's peace, that comprehension and tolerant understanding among men will not stop at national boundary lines. Intolerance is easily perpetuated. Children innately perceive and emulate the attitude of their parents. It is, therefore, indicated that the parents must display the proper attitudes for their children to acquire. Only in this manner can we secure the future of individuals, of society, of nations, and of the family of nations.

MEDICAL ANNALS

of the

DISTRICT OF COLUMBIA

VOLUME XV *May, 1946* NUMBER 5

ECONOMIC TRENDS*

HENRIK SHIPSTEAD

United States Senator from Minnesota

IN MY judgment, no group of professional men is better able to comprehend the nature of economic processes than one composed of men who have been trained in the biologic and medical sciences. Some eminent economists, in fact, have come from your field, in earlier centuries.

As in other human activities, the interpretation of economic processes reflects different approaches. There are, broadly speaking, two major classes of economists. One school of thought sees economic life as a vast series of processes, governed by forces which have their best analogy in the laws of mechanics or physics, moving toward equilibrium. The other point of view regards economic life as something which develops along lines more nearly comparable to biologic growth and mutation. Both schools, of course, are subdivided in numerous ways, and it is not easy to fit every essay on economic theory snugly into these subdivisions. Those whose views belong in the first category have at their head some great names, such as that of Adam Smith; while those who regard what happens in the course of the exchange of goods and services as occurring in consequence of the operation of processes of growth and decay quite analogous to the processes of biologic growth, likewise have great names among their number, the foremost and earliest being the great court physician of France two hundred years ago, François Quesnay (pronounced "Ken-nāý").

The biologic conception is the uppermost today, it would appear; and the reason is obvious. Economic fluctuations, the swing from depression to feverish activity, the consequences of overindulgence in stimulants or sedatives or those of surfeiting with goods or of utter undernourishment, and so on, all have their pathologic analogies. It never does to overstress analogies; one can go astray very easily. But pathology takes in not merely the result of external attack, but also the consequences of organic, biochemic transformation in its analysis of functional disorder, and the readiness to recognize the effect of such causes upon economic life is indicative of more penetrating insight into the nature of economic processes. Indeed, I am told that in other languages than English entire monographs have been written under the titles of "Economic Pathology" and "Social Pathology," and many treatises, while not so entitled, have emphasized this conception of pathologic causes of economic crises.

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So much for the broad background. You are mainly interested in where we are headed now, and at what rate.

This century has been as much a century of bloodshed and warfare as any that went before it for the last thousand years, at any rate. Two great conflicts have so far afflicted mankind in the 20th century, and minor, less widespread convulsions have occurred frequently in these 4½ decades. From the economic point of view, wars are essentially as destructive as from any other point of view.

The recuperative powers are weakened, particularly when peoples have relatively fewer children and younger women; the reconstruction of capital for productive purposes is each time more slowly undertaken. But while war is going on, and while people are getting ready for it, there is always a stimulation of employment, of production, of higher prices, of quick turnover; and some portion of the community tends to look back upon wartime as not without its good points. Men in public life are well aware of the fact that war provides work, and prevents current unemployment, especially war on the great scale of our time, with its nationwide obligatory service in what is called the "war effort." Consequently, men who manage public policy are generally apprehensive of what will take place when war ends. They worry over the let-down of production, the decline in the number of the gainfully employed, the fall in profits, the problem of getting prices and wages down, the rise in public debt, and so on. Their worries often lead them to imagine that there must be some way to have the benefits of war economy without the evil effects of war itself. They listen hopefully to the amateur social physicians who come along with trick treatments of so-called full employment laws or special diets of subsidies. They try these panaceas, sometimes at the same time, in their eagerness to stave off the natural reaction to war.

I am not competent to enter the debate on the autocorrective forces upon which the physician must in some measure depend when grave illness has passed its crisis; but so far as the autocorrective forces of society are concerned, I am inclined to think that our generation gives them much less opportunity to operate than is warranted. For a number of reasons into which there is no occasion to go, this age we are witnessing attaches a great deal of weight to the impersonal, collective wisdom of public authority; we seem to think that the State can do better for any one of us than he can do for himself. We keep loudly repeating our devotion to free competitive enterprise, but we go on contriving new apparatus every day to make its actual practice difficult. The public official is not malicious; he is, in fact, conscientious and well-intentioned; often he works very hard, and he displays remarkable resourcefulness. There are exceptions, of course, but in 30 years of public life I have seen many more praiseworthy, diligent individuals in public service than I have of other less desirable sorts. But the zeal for running other people's affairs is a fixed idea in governmental structures, particularly when the prevailing, popular, political doctrine is that of aiding the people whose income is the lowest and whose living conditions are unsatisfactory. Democracy is understood, in such a period, to mean the rule of the people so as to distribute all income for their benefit and, at the same time, regulate to some extent the use they will make of it.

We are going through a period, in a word, of great concentration of government, of accumulated powers in the hands of the State; and there is widespread acceptance of the notion that the State is responsible for welfare not in the merely negative way of safeguarding the administration of justice and freedom from external interference, but in the positive way of supplementing private action whenever some material improvement in the circumstances of the individual will result.

The prospect, therefore, is one of continued public intervention in economic processes for years to come. No reasonable man will undertake to say how long this will continue, even if he entertains doubt of the permanence or genuinely constructive contribution of this basic trend of public policy. Not only is this true of the United States, but it is true of the rest of the world, with but a few exceptions. Men have come to rely upon, or, at any rate, to put up with, the State as the Chief Conductor of all the economic processes of production and distribution, even of some of those of consumption. It may be that this is accepted silently and all economic activities adjusted, accordingly, to what the State ordains, as in the Union of Soviet Socialist Republics; it may be that conventional deference is still paid to the principles of "free, competitive, private enterprise," as with us; the fact remains, the State is the center of economic policy, not as a moderator who remains outside the processes which he tries to have go on in as orderly a way as possible, but as both lawgiver and baton-wielder, anesthetist, surgeon, and psychiatrist all in one.

In the light of the probable continuation, over a long future, of State-supervised economy, what are likely to be the major characteristics of the trend of costs and of prices, of taxes and the yields of investments, of the volume of production and the rates at which products change hands, and services are in demand?

The trend of costs, including wages, is upward in this country, and in most other large countries. I am speaking, of course, of costs measured in terms of money, and I am not touching the complex question of real economic costs, such as real wages, for the time being. Cost must have a decisive effect on price, even if artificial controls hold that effect in abeyance for a while. Price levels as a whole are therefore going to have an upward trend likewise. For how long, no one can say, except that there is no reason to expect the trend to be altered for several years. Nor can anyone ascertain with certainty at what rate the levels of prices of consumers' goods, and producers' goods, of real property, farms, commodities, securities, and other types of prices will rise during the next 18 or 30 months. So long as there is reasonably full employment, that is to say, so long as every person able to work, and seeking any kind of work within reason that he can do, is successful in finding it, there will be enough income to guarantee an effective demand, and a pretty nearly immediate demand, for all the goods that can be produced, and for close on the maximum of services that can be rendered. Now, goods have been destroyed, the world over, for a half dozen years; and the production of other goods has been delayed or totally disrupted. Staggering reports have been coming in of shortages of food, clothing, fuel, shelter, medicine, the most elementary things of life, throughout the world. India is authoritatively reported to be on the very verge of the most extensive and appalling famine of this century; China will have 3 or possibly 4 great near-famine areas. Not less than one hundred millions of the inhabitants of Asia and the islands of the Pacific are directly threatened by the most precarious food situation at, or scarcely above, famine levels. In Europe many millions are below the standard which Sir William Beveridge, in his famous Report of several years ago, fixed as the lowest level of poverty; in other words, they are destitute. The food experts of the Army say that the winter of 1946–47 may be, perhaps is likely to be, worse than the present winter. For, behind what Mr. Churchill yesterday called the "iron curtain" stretching from Stettin to Trieste, vast armed forces of the Soviet Union are anchored in Europe's breadbasket, the Hungarian plains, and other Eastern areas, consuming all the production, even to the point of jeopardizing the food supplies of the farmers themselves. The Soviet Union may have learned much since the farmers of Russia itself were starved and slaughtered two decades ago, but I have seen little evidence of it. An increase of 30 per cent in mortality rates for Continental Europe west of the "iron curtain" during the calendar year 1946 would not be too much to expect, and again an even larger increase in 1947; and for much of

Asia, mortality will rise to levels not recorded in centuries.

So that food, medicine and clothing will be in constant demand. Who will pay the producers? A few States abroad are solvent; and great charitable establishments and enterprises will do much to relieve distress. But much will be needed by those who can pay nothing. This Nation of ours, through action of its Congress, will have to take the lead in furnishing food, medicine, and clothing, and other necessities on credit or out of charity with no hope of payment.

At home we are short of essential living quarters, and either through conversion and reconstruction of existing structures, or through new construction, we must contrive to provide living space for some millions of people. I need not mention the vast array of machines needed, and in some cases, as in that of agricultural machinery, desperately needed for the objective of maximum production of food supplies.

In a few months, we may suppose, the major controversies over rates of wages will be over. It is possible that a period of half a year or more may then follow during which a great deal of conflict over jurisdictional control will follow within the ranks of labor itself; and that, too, will serve to delay production and retard the flow of goods, if not as much as the current controversies. But before long, in any case, the wage levels will have risen enough to get the output of industry back to levels relatively higher than before 1942, if not quite to wartime volume.

Well, if volume of goods produced and distributed is maintained at a high level, and prices rise, and costs remain incompressible, if not actually expanding, then, is there not a reasonably promising prospect of activity ahead of us for a few years?

I answer my own question. If the weather and other natural factors are as favorable as they have been for 5 years, the production side of our economy will be reasonably promising during the next 2 critical years. We shall somehow survive, should all these factors fall into place as I have supposed; and my supposition is wholly conjectural only in one respect, namely, the weather factor in 1946, as to which we can only most anxiously hope.

But there is another side to all this, namely, the financial, public debt side, the effect on private property, interest rates, and the stability of the middle class.

For 16 years our Federal Government has been spending much more than it received in nonborrowed revenue of any description. The excess of expenditure over revenue averages out at over half a million dollars ever hour for the last 16 years. Most of this has gone in war costs, but even without the War, we were running behind fully one hundred million dollars every week. The interest on the public debt is running this fiscal year at the rate of 10 per cent of all the Treasury receipts from other sources than borrowing. I suppose that as long as it does not cost us in interest as much as we can raise by taxation to go on creating debt, we are technically in a position to continue for years with this reckless policy. The statutory limit on the public debt is now three hundred billion dollars. There is no doubt that it will be raised to another limit when we have spent ourselves up to the three hundred billion ceiling. I venture no prediction as to the maximum public debt, but I feel certain that we are far below it today, although we have a total public debt of about two hundred and eighty billions.

Much of this debt will mature within a few years; it is, in fact, to the extent of over a third, nothing but floating debt, that is, debt with a maturity of less than 5 years. Ordinary financial prudence warns governments, as well as individuals, to keep out of tight corners caused by having to face too many maturities at about the same time. But for reasons of political prestige the Treasury has seen fit to set a very low interest rate, and though the enormous mass of its operations, it has had all lenders at its mercy. Despite all of its loud assurances of wanting to get the public into the habit of buying public securities, it has focused its entire borrowing policy for a dozen years upon the banks, selling to them short term securities which created vast bank deposits, and these bank deposits have in turn been reinvested in government securities, then creating other deposits and so on. The Treasury policy has been reckless and destructive; and there was never any need for the course which it persisted in following. Our neighbor, the Dominion of Canada, has raised a proportionally great sum of money by finding out what rate would attract permanent public buying of government long-term and intermediate-term bonds; and it has paid that rate. The result is the banking system of Canada has not been converted into a great investment syndicate, with a huge, undigested, perhaps indigestible, mass of short-term, low-interest obligations which cannot be distributed to the public and cannot be withdrawn without risk of a grave dislocation of the price structure. Large-scale contraction of bank deposits would precipitate liquidation of prices and wages, and there is no sign that we can expect that in the next few years.

The outlook for investment yields is overcast. Of course, security prices have risen and will continue rising even if violent fluctuations occur from time to time. But the operating costs of all enterprises will rise; and both dividends and interest payments will suffer from this inescapable burden, as well as from the constant rise of tax rates, state and local, as well as Federal. There is no prospect in the near future of any reduction in the per capita rates of taxation of all sorts in this country. This fact balances any advantages which the direct ownership of property has over the ownership of claims on the future earnings of property, that is, shares and bonds and other securities. To be sure, property, both rural and urban, and commodities, have tangible worth which mounts when replacement costs climb, but the relentless demand of the tax gatherer is right there the moment the owner tries to realize upon that increase in replacement worth.

The fundamental truth is that for a generation the so-called civilized world has been living upon its economic accumulations and wearing out the entire apparatus of its economic life. This pathologic situation has not run its course; and perhaps it has not yet been correctly diagnosed. We may as well make up our minds that we have yet a long way to go before we even know the direction the future will see us taking. You encounter in your day-by-day experience progressive enfeeblement of the individual organism, and the economic historians tell us that progressive impoverishment has all too often marked the protracted senescence of a vast region or an entire epoch. Over-exhausted States do not need to die by violent assault from other States; they succumb to the consequences of their unbalanced and reckless disregard of the requirements of realistic adaptation of individual or group life to the resources within reach.

THE PRESENT STATUS OF PENICILLIN THERAPY OF SYPHILIS*

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Penicillin appears to be the most effective and least toxic drug so far discovered for the treatment of syphilis since Ehrlich's synthesis of salvarsan. At the present time, however, treatment schedules are still experimental and relapse rates of 15 to 25 per cent occur depending upon the amount of penicillin used as well as on the duration of treatment.

Evaluation of the effectiveness of any antisyphilitic therapy has always been difficult, and penicillin treatment is no exception. Although some investigators believed that the problem of penicillin therapy of syphilis could be solved in a short period of time, the more cautious feel that the investigation is a long-term one, requiring at least 5 years for the evaluation of early syphilis and a considerably longer period for the late and complicated forms of this disease. Since syphilis is a disease of prolonged chronicity, the efficacy of any chemotherapeutic agent can only be determined after extensive and careful observation. The problem of statistical evaluation becomes further complicated by the fact that over such an extended period 80 to 90 per cent of the patients are lost for "follow-up."

Penicillin was first applied to the treatment of syphilis by Mahoney[1] of the U.S.P.H.S. He treated 4 patients with primary syphilis using 20,000 units intramuscularly every 3 hours for 60 injections, or a total of 1,200,000 units in 7½ days. All subsequent treatment schedules have been variations of this original scheme. Two factors have been kept constant in most subsequent methods of treatment, i.e., the intramuscular route of injection and the 3-hour interval between injections. The variations have been in the amount of penicillin used and the duration of treatment. Further modifications have been made by the addition of relatively small amounts of arsenoxide (mapharsen) and bismuth to the treatment schedule.

The Rapid Treatment Center at Gallinger Hospital, Washington, D. C., has been privileged to take part in the organized study for the evaluation of penicillin treatment of syphilis. This study is being carried out under the direction of the U.S.P.H.S. in coöperation with the penicillin panel of the National Research Council. In the earliest studies only selected cases were chosen, those with lesions positive for Treponema pallidum by darkfield examination. This essential critèrion for diagnosis was used because a positive darkfield is the most specific test for syphilis. Many skin eruptions may simulate secondary syphilis, and a positive serologic test may not always be indicative of this disease.

Treatment Schedules

The first schedule used on any considerable scale consisted of a total penicillin dosage of 1.2 million units administered at 3-hour intervals or 20,000 units for 60 injections over a period of 7½ days. With this treatment lesions generally became darkfield negative within 18 to 24 hours and the healing process of the lesions was markedly accelerated. Quantitative serologic tests were made prior to and at the termination of treatment and at monthly intervals for at least 1 year wherever possible. Under this plan of treatment clinical or serologic relapses or reinfection occurred in about 25 per cent of the cases.

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The next series of patients was divided into 2 groups. One group received 40,000 units every 3 hours for 60 doses, the second 80,000 units every 3 hours for 30 doses. The total in each group was 2.4 million units of penicillin. In the first group the relapse rate was about 20 per cent, while in the second, or 30-dose schedule, the relapse rate was higher, 28 per cent. This whole series consisted of only 70 patients, 40 of whom were followed serologically for 6 months. From this small number, clinical judgment indicated that a further increase in the total dosage might result in progressively fewer failures.

At about this time a further variation was introduced. Several investigators, particularly Eagle and his co-workers,[2] have shown that a synergistic action occurs if arsenoxide or arsenoxide and bismuth are administered at intervals during penicillin therapy. Accordingly, several schedules were tried, with combinations of penicillin, arsenoxide and bismuth subsalicylate. The following protocol shows the amounts of each drug used:

SCHEDULE OF TREATMENT	PENICILLIN IN UNITS	ARSENOXIDE IN GRAMS AND DOSES	BISMUTH SUBSALICYLATE	DURATION OF TREATMENT
1	600,000	0.06 Gm. × 8	0. 2Gm. × 3	8 days
2	1,200,000	0.06 Gm. × 5	0	10 days
3	1,200,000	0.06 Gm. × 5	0.2 Gm. × 3	10 days
4	2,800,000	0.06 Gm. × 5	0.2 Gm. × 3	14 days

The first treatment schedule produced several moderately severe arsenical reactions as well as 2 nonfatal encephalopathies. The cure rate was too low to be considered satisfactory. The second and third were improvements and showed that a further extension of the treatment time as well as an increase in the amount of penicillin were indicated. The fourth and most recently attempted schedule of 2.8 million units of penicillin, 5 doses of arsenoxide and 3 of bismuth appears to be the most successful combination. We can say tentatively that the failure rate appears to be about 15 per cent.

The above treatment schedules, briefly described, are only a few among those tried in the nationwide study. There is a definite indication, however, that an approach has been made to the maximum effective treatment schedule. It is also apparent that there is a synergistic action when arsenoxide or arsenoxide and bismuth are used in conjunction with penicillin.

Only brief mention can be made of other penicillin products in the treatment of syphilis. From the point of view of a more practical treatment procedure any product that is slowly absorbed after intramuscular injection would be most desirable. Furthermore, a treatment suitable for use on an outpatient basis is a hoped-for goal. Penicillin in a beeswax-peanut-oil mixture has been found effective in the treatment of gonorrhea by several workers, notably Romansky,[3] Van Slyke and Heller,[4] and Chinn, Olansky and Murphy.[5] In gonorrhea it is necessary to maintain penicillin blood levels for a comparatively short time, but in syphilis it is apparently necessary to maintain a constant effective blood level over a period of at least 10 days and perhaps 14 days or longer. Kirby, Leifer, Martin and Rammelkamp[6] have shown that after intramuscular injections of 300,000 units of a penicillin-peanut-oil-beeswax mixture 69 per cent of 54 cases maintained levels for 12 hours, and 31 per cent had levels for 16 to 28 hours. The shortest duration was 4 hours.

Although an extensive series has not yet been carried out, we have a definite impression that penicillin-beeswax mixtures are just as effective in the treatment of primary and secondary syphilis as is sodium penicillin in water solution. Total penicillin dosages of 3 to 4 million units

(300,000 to 400,000 units per single daily dose) have been used in cases treated with penicillin-beeswax. To date a small series of 40 cases has been treated with the penicillin-beeswax-peanut-oil mixture. Of these, 36 cases were serologically negative after 6 months, 2 are still positive after 9 months, and 2 are considered relapses.

The use of oral penicillin preparations in syphilis leaves much to be desired. Although effective blood levels can be obtained in some cases, they are, for the most part, uncertain and variable. Absorption through the gastrointestinal tract varies greatly with each patient, and considerably larger amounts of penicillin are required to maintain adequate blood levels. It is hoped that oral preparations will not be used in syphilis, since the maintenance of regular treatment depends entirely upon the patient, who frequently forgets to take his medication and will not, it is feared, take his treatment seriously. These difficulties were encountered when gonorrhea patients were treated with oral preparations. If penicillin-resistant strains of treponema or gonococci can develop, this is probably the way to do it.

Treatment of Other Forms of Syphilis

It has constantly been asked whether penicillin can be used for all forms of syphilis. We believe that it can be said with considerable surety that penicillin is effective in primary, secondary, and very early latent syphilis. Comparatively little work has been done on late latent syphilis, and no conclusion can be arrived at regarding the penicillin therapy of this stage of syphilis. The same can be said of cardiovascular syphilis, but it can be assumed that penicillin, used cautiously to avoid generalized reactions, may prove to be effective.

Several reports have appeared regarding neurosyphilis. Here again treatment schedules are quite nebulous. There are indications that penicillin plus chemotherapy or penicillin in conjunction with fever therapy is more effective than penicillin alone. Where encouraging results have been obtained, the amount of penicillin used has been considerably greater than that used in early syphilis. From 6 to 10 million units over a period of 15 to 21 days is probably close to the effective total dose. The spinal fluid level of penicillin does not reach a high concentration, but it has been shown that it is not necessary to inject the penicillin by the direct subarachnoid route. The results so far reported in the treatment of neurosyphilis compare favorably with the older methods of treatment. Penicillin improves the spinal fluid in all its elements and to a lesser degree the blood serologic reactions. The spinal-fluid cell count and protein showed a general reduction and is later followed by a decrease in the Wassermann titer. The greatest clinical improvement was seen in cases of paresis and primary optic atrophy.[7,8] The advantage of the newer method is in the short duration of treatment and its high tolerance for most patients.

The treatment of syphilis in pregnancy has shown spectacular results in the hands of most investigators. At the Gallinger Hospital Rapid Treatment Center 149 women were treated during pregnancy. Only 1 infant was born with congenital syphilis from all these cases and this in a woman who began treatment 2 weeks before term. The schedule used in these cases was the one in current use at the time of admission to the Rapid Treatment Center. All received at least 2,400,000 units of penicillin, but some were on a schedule which included arsenoxide or arsenoxide and bismuth. With the older methods of treatment with arsenic and bismuth, not only would the treatment have been greatly prolonged, but a considerably lower percentage of normal babies would have been obtained. It must be emphasized that in penicillin therapy the mother may not have been cured by the treatment during pregnancy although she may have delivered a normal child.

Serologic Response

The serologic and spinal fluid follow-up are of the utmost importance as criteria for cure. Quantitative blood tests should be carried out monthly for at least 1 year post-treatment and then periodically at less frequent intervals. The titer begins to fall shortly after treatment is completed, and a continouus decrease should be noted in successfully treated cases. Serologic relapse is most likely to occur within the first 6 months. If serologic or clinical relapse occurs, re-treatment is indicated. Spinal-fluid examination should be made 6 months and 1 year post-treatment, and, if possible, after 2 years.

Relapse is difficult to differentiate from reinfection if the latter actually occurs. It is generally agreed that a "known case of syphilis who has been treated, whose blood and spinal fluid has reverted to negative with the disappearance of lesions, and who returns with a history of reëxposure, the appearance of a lesion at a site other than the original site and is darkfield positive, would be considered a reinfection."

A clinical relapse may be defined as "occurring in any patient who, 30 days after treatment, exhibits mucocutaneous lesions which are darkfield positive, or shows a reversal to positivity of the blood or a persistent increase in serologic titer of the blood." A serologic relapse has been defined as occurring if, "after 2 preceding serologic tests are negative over a period of at least 2 months, the tests become positive in undiluted or in any dilution of serum, confirmed by 2 subsequent tests at a minimum of 10-day intervals of equal or increasing positivity, subject to consideration of intercurrent disease. If the preceding tests were positive in a constant or decreasing titer, a serorelapse is defined as 2 consecutive serologic tests, positive at a minimum interval of 10 days, the titer increasing with a constant upward trend." Wherever doubt existed as to reinfection, the case was considered a relapse and therefore a treatment failure.

It is possible to predict a clinical relapse on the basis of a serologic relapse. In conjunction with Lt. Colonel Charles R. Rein of the Army Medical College a number of cases were followed serologically. A battery of tests were performed monthly. In almost all cases in which an increasing serologic titer occurred, clinical relapse could be demonstrated eventually by the presence of mucocutaneous lesions with a darkfield examination positive for Treponema pallidum.

REACTIONS

Reactions as a result of penicillin occasionally occur. Herxheimer reactions frequently develop but are not considered contraindications for the continuation of treatment. Herxheimer reactions may be dangerous in late or complicated syphilis and treatment should be instituted with caution. Dermatoses of a mild nature are not infrequent, and occasionally severe reactions occur with urticaria, severe itching, and fever. Leavitt[9] has claimed that penicillin preparations may initiate menstruation and may even activate the uterus so as to produce abortions. This has not been substantiated, and we have not noticed this side effect. In our series of 149 pregnant women treated with penicillin not a miscarriage occurred.

Fungus allergy has been observed. Patients with mycotic infections show hyper-response in areas of the skin previously inhabited with fungi. Substances are probably present in the impure penicillin related to the products of fungus growth.

Sterile abscesses have occurred only where penicillin has been inadvertently inoculated subcutaneously, never when correctly inoculated intramuscularly. Continuous low-grade fever sometimes occurs throughout the treatment period and is probably due to impurities in the preparation.

A brief word must be made regarding the treatment of gonorrhea with penicillin where the possibility of a concurrent syphilitic infection exists. Penicillin therapy for gonorrhea may prolong the incubation period and mask the symptoms of syphilis if the latter is contracted simultaneously. Serologic tests for syphilis should be made at the first visit and 30, 60 and 90 days after treatment for gonorrhea. Walker and Barton[10] advise that if there is evidence or suspicion of coëxisting syphilis, penicillin treatment for gonorrhea should be withheld until a definite diagnosis is established or eliminated and the gonorrhea treated with one of the sulfa drugs. We feel, however, that it is better to treat the gonorrhea and emphasize the importance of serologic follow-up.

Discussion

The treatment of syphilis with penicillin is still in an experimental stage. Penicillin, or some similar antibiotic, will undoubtedly prove to be the most effective and safest antisyphilitic drug so far developed. In relative freedom from toxicity it is unquestionably superior to the arsenicals and, furthermore, provides a rapid form of therapy. In the older extended methods of treatment only about 15 to 20 per cent of syphilis patients ever completed treatment. In the present rapid treatment methods with penicillin almost 100 per cent complete the required course of treatment. From the public health point of view this means that fewer infectious patients are allowed to go free to spread their infection. Furthermore, it is generally conceded that the stationary or slightly decreasing syphilis rate in the civilian population during the past 2 years has been due to the immediate isolation and treatment of many of the most infectious cases in rapid treatment hospitals.

The optimum effective dose has not yet been established for any of the forms of syphilis, but it is evident that at least 3,000,000 to 4,000,000 units are required for the early forms of syphilis (up to 2 years' duration) and 6,000,000 to 10, 000,000 units in neurosyphilis. The duration of treatment is probably about 14 days in early syphilis and up to 20 days for late syphilis.

There is a serious responsibility placed upon physicians treating syphilis with penicillin. The question of the diagnosis of syphilis is often difficult to make and frequently depends upon blood tests only. A positive serologic test, however, is not always an indicationof the presence of a syphilitic infection, particularly if clinical evidence is lacking. A diagnosis of syphilis not only involves the patient in a long, expensive, and perhaps painful course of treatment but places the stigma of syphilis on the individual with possible subsequent psychic trauma. So-called "false positive" blood tests occur in individuals who have recently had such diseases as pneumonia, influenza, or malaria, or in people with recent immunization against smallpox, typhoid, typhus, influenza, and other diseases. The false positive tests are transient and usually of a low degree of positivity. When such results are obtained, a careful history is of importance and periodic quantitative blood tests must be made. It is always better to delay treatment than make a hasty and incorrect diagnosis.

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CHEMOTHERAPY OF CHRONIC SUPPURATIVE DISEASES OF THE LUNGS AND PLEURA*†

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Twice in the past ten years chemotherapeutic agents have been introduced with the prospects of being helpful in the treatment of chronic suppurative diseases of the lungs and pleura, namely, bronchiectasis, lung abscess and empyema. In each instance it was hoped that these drugs would supplant surgery, which has made remarkable strides in its own right during the same period. Although several sulfonamides have been employed, the therapeutic results in this group of pulmonary diseases are similar and therefore can be considered together. Penicillin, which has the advantages of being essentially nontoxic and uninhibited in the presence of pus, has not received an extensive trial, but ample data have been accumulated to allow for preliminary evaluation.

BRONCHIECTASIS

Bronchial and bronchiolar destruction, dilatation, and chronic infection are salient features of bronchiectasis. The anatomic changes accompanying bronchiectasis are permanent. The possibility of restoring normal structure and function by medical measures is not a likely one, but partial elimination of infection would be expected to have a favorable effect on the symptoms and on the natural course of the disease. Prolonged morbidity aggravated by bouts of pneumonitis resulting in death in a relatively few years due to infection or respiratory embarrassment or both is otherwise characteristic of bronchiectasis.

Therefore, in a discussion of the medical treatment one must start with the premise that the best therapy is surgical, pneumonectomy or lobectomy. However, there are patients on whom operation is impossible because of the extensive involvement, poor general condition, or refusal of the patient to submit to surgery. Some observers believe that patients with slight involvement may escape surgery with conscientious medical care. In all cases treated medically proper postural drainage must be maintained faithfully by the patient.

Sulfonamides have been used in various forms in the treatment of bronchiectasis, orally, by intratracheal or intrabronchial instillation, and by inhalation. Norris[1] found a considerable reduction in daily sputum volume with favorable alterations in the bacterial flora following oral and intratracheal or intrabronchial administration of the sulfonamides. The oral route seemed preferable, since an average of 60 per cent of the blood sulfonamide level was found in the bronchial secretion. Furthermore, daily instillations into the respiratory tract would be necessary, since significant concentrations of the drug persisted in the bronchial secretion for only 24 to 48 hours. Norris found it difficult to get an even instillation of the drug into the bronchial tract and noted the danger of the development of atelectasis from plugging of a small bronchus. His conclusion was that sulfonamide therapy should prove to be of definite value as preparation for lobectomy or pneumonectomy. Other investigators[2,3] have since reported similarly good temporary results with the instillation of sulfonamides into the bronchial tree. Thomas, Van Ordstrand and Tomlinson[4] in a recent article concluded that all nonsurgical cases should be given an adequate trial of sulfonamide therapy plus allergy management when necessary. In the majority of patients improvement entailing at least 50 per cent reduction in cough and expectoration occurred. However, exacerbations were frequent when the sulfonamides were discontinued; but almost invariably if the drugs were repeated when symptoms first began to return to their former severity, continued improvement could be maintained. These authors thought that repeated courses of the sulfonamide drugs continued long enough to secure maximal improvement and given not more than every 3 or 4 months was probably the method of choice rather than continuous small doses. With the former method there is less danger of producing untoward reactions and of causing the bacteria to become sulfonamide-resistant. Castex and his co-workers[5] demonstrated that inhalation of a 5 per cent sulfanilamide solution resulted in clinical improvement. Stacey[6] has also reported marked improvement after inhalation of nebulized sodium sulfathiazole in patients with bronchiectasis. Again, the results were temporary, of transient value, and with recurrence of infection upon discontinuation of the treatment. In a summary of the management of bronchiectasis, Alexander[7] concluded that the results of sulfonamide therapy in bronchiectasis have been generally disappointing, although in a few patients the results were satisfactory.

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Our own experience has been that the sulfonamides usually control a superimposed pneumonitis. For the treatment of the disease itself, most patients receive temporary benefit while on the drug, only to relapse when the drug is discontinued or an upper respiratory infection supervenes. No patient has been cured, although some with a mild form of the disease have remained symptom-free for relatively long periods of time. Repeated courses of the sulfonamides appeared more beneficial than continued small doses. Some patients were not helped at all.

Penicillin is undergoing a trial in the treatment of this chronic suppurative disease of the lungs. Stookey et al[8] reported that the true bronchiectatic showed little or no response to the administration of penicillin. On the other hand, Bobrowitz and his co-workers[9] thought the results of penicillin therapy to be remarkable. They treated 12 cases of severe bronchiectasis with penicillin administered intramuscularly, by inhalation, or by intratracheal injection in doses of 550,000 to 5,500,000 units for periods of 4 to 115 days. Of the various methods of administration inhalation was the simplest, but intratracheal the most rapid in its effect. The highest sputum-penicillin levels were obtained with the latter method, and the lowest with intramuscular administration. As long as penicillin was continued, the amount, odor and purulence of the sputum were considerably diminished and the number of organisms reduced. Symptomatic improvement was apparent. They suggested penicillin therapy as a form of preöperative preparation for lung resection, and as symptomatic therapy for nonoperative cases administered for long periods of time or even indefinitely. Recently Kay and Meade[10] in a large series of cases demonstrated penicillin, administered intramuscularly or intratracheally, to be of no permanent value in the treatment of advanced bronchiectasis. One third of the patients treated noted no improvement. The remainder displayed some benefit, although the authors admitted the results obtained were intangible and difficult to analyze. In some patients the sputum decreased and changed in character, while in others the amount of expectoration increased. Most patients felt that they were generally stronger and their appetites were better. The greatest amount of benefit was noted within the first several weeks of treatment, and thereafter there was little change. Even though improvement was noted, some symptoms of sepsis and productive cough persisted. Three to 4 weeks after penicillin was discontinued symptoms invariably became aggravated. The authors thought that intratracheal administration of penicillin appeared to give more benefit in many cases than the intramuscular route. Barach[11] and Segal and Ryder[12] observed that aerosol penicillin produced temporary improvement in bronchiectatic patients and even in patients in whom intramuscular penicillin had been ineffective. The latter investigators recommended repeated courses at 3- to 6-month intervals. The experience at the Mayo Clinic[13] with aerosol penicillin has been essentially the same as that of the other investigators. The conclusions of this group are that over 50 per cent of the patients are helped although the results are temporary, that penicillin is of value in cases not amenable to surgery, and it is excellent for preöperative preparation. This group[14] have since extended their observations of the treatment of bronchiectasis to include a study of the use of streptomycin alone or in combination with penicillin by nebulization and by instillation into the trachea. They had previously noted failures with penicillin when the predominant organisms in the sputa were gram-negative. Streptomycin employed in these patients produced an immediate reduction in the volume of sputum, which became thinner and less purulent. The gram-negative bacteria disappeared from the sputa and improvement in the general condition was noted. They concluded that the usefulness ascribed to penicillin could be extended to streptomycin when gram-negative organisms were present. Our own experience with intramuscular penicillin has been similar to that with the sulfonamides.

Lung Abscess

Although there are reports as to the effectiveness of the sulfonamides in the treatment of lung abscess, the influence of these drugs is best summarized by Sweet[15] in a review of the cases treated at the Massachusetts General Hospital. He found that there was no significant difference in the mortality and no material change in the morbidity. In our experience, as well as that of others, some acute lung abscesses may heal spontaneously with adequate postural or bronchoscopic drainage. With the use of the sulfonamides the incidence of cure is increased in a small percentage of cases. Perhaps the value of these drugs lies in their ability to control the associated pneumonitis. In a review of 63 cases of lung abscesses seen at Gallinger Municipal Hospital over a 5-year period, the sulfonamides appeared to have exerted no appreciable beneficial effect except to decrease the amount of expectoration and degree of toxicity. Prior to the introduction of penicillin it was felt that all patients with acute lung abscess should be given a trial of sulfonamide therapy combined with adequate drainage, postural or bronchoscopic. If after a period of 6 to 8 weeks the abscess was not essentially healed, surgical intervention should be instituted despite a decrease in cough, expectoration and constitutional symptoms. Earlier operation should be performed if there is no improvement after 10 to 14 days of treatment. Sometimes the sulfonamides have been detrimental because one has been lulled into a false sense of security with the decrease in respiratory symptoms and toxicity. Operation is therefore delayed, and in the interim the patient may develop a metastatic abscess, or when finally allowed to go to surgery he is a poor risk either technically or as a result of the general condition.

The few articles on the use of penicillin appear favorable. Smyth and Bellingslea[16] recently reported cures in 4 cases of lung abscess, 3 acute and 1 chronic, treated with penicillin for 37 to 166 days. They reviewed the literature and collected 31 cases, 13 of which were cured, 8 improved, and 10 not benefited. These authors felt that perhaps more prolonged treatment would have produced a higher percentage of recoveries. Five additional recoveries have been reported by Blake and Craige,[17] and Kullman and Crellin.[18]

In our hands penicillin administered over prolonged periods has proven to be of limited value in the treatment of 9 patients with lung abscesses. Although there was improvement in the general condition and decrease in expectoration, all patients except 1 have ultimately had to come to surgery. One case of acute abscess is still under treatment and is apparently responding satisfactorily.

Segal and Ryder[12] conclude that aerosol penicillin should be employed in all cases of multiple lung abscesses, acute or chronic, for courses as long as 4 to 10 weeks; and after a suitable rest period another course may be given if necessary. They believe it may be possible to avoid surgery in these cases with an effective program of penicillin aerosol, particularly if the abscess is postpneumonic, aerobic and nonodoriferous. They do not believe that penicillin would be effective in the anaerobic, odoriferous type of abscess. Whether such long courses of penicillin should be maintained in the presence of an unhealing abscess awaits further trial. It appears, however, that the same pitfalls observed with the prolonged use of the sulfonamides in a persistent abscess are present.

Probably one of the most important factors in the failure of systemic chemotherapy in pulmonary suppuration is the inability of the drug to reach the abscess where there is poor blood supply. The local application of sulfonamides is ineffective because they are inhibited by pus. Aerosol penicillin has the advantage of acting locally even in the presence of pus.

Penicillin deserves a trial for at least 6 to 8 weeks in the treatment of lung abscess providing continued improvement is evident. Whether the inhalation or intramuscular method of administration will prove to be the best form of therapy awaits further investigation. If at the end of that period the abscess is not essentially healed surgery should be instituted. Penicillin has been found highly efficacious pre- and postoperatively in the prevention of some of the complications of surgery.

Empyema

The treatment of empyema embraces two principles: sterilization of the exudate within the pleural space and obliteration of this space by reëxpansion of the lung. The present-day accepted method of treatment is adequate surgical drainage. There are, however, disadvantages in this form of treatment. The use of simple multiple aspirations offers little hope for cure, although it has been used with success on rare occasions. Following the introduction of the sulfonamides it was soon learned that these drugs given orally or intrapleurally were ineffective because they were inactivated by the pus. In 1941 Keefer and his associates[19] reported recovery in 4 cases of streptococcal empyema treated with multiple aspirations and sulfonamides, although they concluded generally that sulfonamides did not obviate the need for open drainage or shorten the course in most cases. There are other reports on the successful treatment of empyema with multiple aspirations and the use of these drugs. Recently Josey, Trenis and Kammer[20] reported 11 cases successfully treated in a similar fashion. Other investigators [1, 22] have reported disadvantages in the use of sulfonamides in empyema. They believed that the pus was thickened and more tenacious with tendency toward loculation, and open drainage was required sooner.

The introduction of penicillin stimulated a revival of the nonsurgical treatment of empyema and as a result has caused a considerable degree of controversy as to adequate treatment. It is established that intrapleural penicillin is needed because it is absorbed poorly into the pleural space when given parenterally. Adjunct intramuscular penicillin has been used in the presence of underlying disease. Tillett and his coworkers[23] were among the first to report excellent results in 7 out of 8 cases of empyema treated by intrapleural instillations. Since then they have reported 13 additional cases cured with similar treatment.[24] Six additional articles[25–30] have appeared reporting a high incidence of cures with intrapleural penicillin, even in cases of empyema secondary to a bronchopleural fistula. The best results were obtained in postpneumonic empyemas. On the other hand, other investigators[31–34] have reported results which contrast markedly with those of Tillett and others; Blades reported 2 out of 23, Poppe 2 out of 35, and McAdam none out of 11 patients recovering without surgical drainage. These latter investigators suggest that the reason for the good results of the other group is that they were treating incipient or merely infected pleural effusions in most instances rather than true, frank empyemas. Furthermore, Blades and Poppe both agree that even though penicillin sterilizes the empyema fluid, ultimately this fluid has to be drained. Tillett and others believe that the sterile empyema fluid will absorb if sufficient time elapses. Blades, Poppe and Roberts state further that following penicillin therapy the pleural walls become thick and fibrous similar to a chronic empyema of several years' duration, making drainage more difficult and thoracoplasty frequently necessary. Unexpandable lungs have been reported occasionally by both groups.

We have treated 9 patients with empyema with penicillin intrapleurally every other day in doses of 20,000 to 50,000 units for 1 to 3 weeks. Pneumococci were isolated from the fluid in 6 patients, the empyema following an inadequately treated pneumonia in each instance. Two patients in this group recovered, while 3 ultimately required a thoracotomy. Another appeared to recover, only to have a recurrence requiring surgical drainage. A patient with a mixed tuberculous and hemolytic Staphylococcus aureus empyema had a similar course. Still another patient with a hemolytic streptococcal empyema, postpneumonic, responded at first but finally required a thoracotomy. The last patient with a Hemophilus influenzae empyema appears to have recovered.

SUMMARY AND CONCLUSIONS

It appears that chemotherapy should be reserved for patients with bronchiectasis not amenable to surgery. The sulfonamides have the advantage of being effective orally, but they may cause serious toxic symptoms. The recent advances in aerosol administration of penicillin will most likely make this the drug of choice, since it is nontoxic and uninhibited in the presence of pus. Patients with lung abscesses deserve a trial of penicillin therapy. The preference for this drug is obvious, particularly with aerosolization, which deposits the drug at the site of the abscess. Surgery should not be postponed if improvement is not manifested within several weeks or even in the presence of improvement with the abscess persisting after 6 to 8 weeks of treatment. The value of penicillin in preference to surgery in empyema depends on the final evaluation of the consequences of residual sterile empyema fluid. All investigators agree that a trial of penicillin intrapleurally for 7 to 10 days seems warranted. If the infection is not controlled within this period surgical drainage is indicated.

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A CASE OF UTERINE ATONY REQUIRING A LARGE AMOUNT OF BLOOD AND PLASMA

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THE conduct of the third stage of labor has become a rather standard procedure in most hands since the development of a relatively satisfactory and rational method.[1] The soundness of this method and its modifications has been borne out by statistical analyses,[2, 3] by a constantly falling death rate from hemorrhage, and by the infrequency of serious complications.

Development of such a method has taken many years; meanwhile various contrasting procedures have enjoyed a transient vogue since the time when the savages caused the expulsion of the placenta by tickling the nose of the parturient. Crede,[4] the pioneer in methods of intervention, proposed that the uterus be squeezed to force out the afterbirth just as one expels the pit from a cherry, but the pendulum soon swung the other way, and Ahlfeld,[5] who considered Crede's method harsh and unphysiologic, proposed a purely expectant therapy, that of merely standing by for 2 hours to await spontaneous delivery. He decried even touching the uterus during this time, but if the placenta had not appeared at the end of the stated period he advocated the use of the Crede maneuver. A middle of the road therapy was proposed by John Harvie (1767): the uterus should be guarded lightly by the hand for 15 minutes, after which time a gentle expression of the placenta was to be used. This technic persisted through the years until 1933, when Calkins[1] introduced his modification in the handling of this stage of labor and demonstrated conclusively its value in the conservation of blood. His method, or a reasonable semblance thereof, is the one in general use today; it consists essentially of determining placental separation by the change in shape of the uterus from a soft, flat surface to a globular one, and initiating the expression of the placenta by utilizing the uterus as a piston to push it from the lower uterine segment of the vagina.

The use of purified pituitary oxytocic fractions and the active principle of ergot has enormously reduced the blood loss during this stage of labor, has decreased the incidence of postpartum hemorrhage to a fraction of its former figure, and has made childbearing a much less hazardous procedure, but on rare occasions one still finds uterine musculature which will fail to respond to such drugs. The following case is presented to emphasize the need that large amounts of blood and plasma should be readily available to any hospital where obstetrics is being carried out.

Report of Case

A 23-year-old female, para 0, gravida 1, with a normal pelvis, was registered in her 12th week of pregnancy. The last menses occurred on October 11, 1944, and the expected date of confinement was approximated at July 21, 1945.

The family history was not remarkable. She had been married for 1 year, and this was the first pregnancy. The menses had always been regular on a 26-day cycle, lasting 4 days, 3 pads being used a day. She had had the usual childhood diseases without sequelae, and a review of the systems was essentially negative. There had been no serious illnesses and no operations save for excision of a cyst of the right breast in 1938.

Physical examination showed a well built female of medium height, 65½ inches, weighing 123 pounds, with a temperature of 98.6°F., a pulse rate of 82, a respiratory rate of 22, and a blood pressure of 118/70. There were no outstanding stigmata of endocrinopathy.

The teeth were excellent and the tonsils small. No thyroid enlargement was noted. The breasts were moderate in size and the nipples erect; no masses were felt. The heart was normal in size, and no murmurs were heard. The chest was symmetrical; the lungs were clear. The abdomen was scaphoid. The liver, kidneys and spleen were not felt. A mass was palpable just above the symphysis, thought to be the uterus.

Pelvic examination showed Bartholin's and Skene's glands to be normal. The vulva, vagina and cervix were softened and blue, and Hegar's sign was positive. The uterus was anterior, enlarged to 10 to 12 cm. in diameter, soft and boggy. The adnexal regions were negative; the cervix was clean. Pelvic measurements were: interspinous 26 cm., intercrestal 27, intertrochanteric 32, Baudelocque 19. The diagonal conjugate was not reached at 12 cm., and the spines were not prominent. No convergence of the side walls was noted.

The blood analysis showed the hemoglobin to be 83 per cent, the white blood count 10,850, blood type O, the Kahn negative, and the Rh factor positive. The urine was normal.

The patient was seen at monthly intervals for the first 7 months, and quickening was noted on February 19, 1945 (19th week). In the 8th month she was seen at bi-weekly intervals, and in the ninth month at weekly intervals.

During the pregnancy she had gained 22½ pounds. Her blood pressure varied between 100/70 and 120/80, and no edema or albuminuria had been noted. Any complaints voiced were minor ones.

On July 18, 1945 at 2:30 p.m. the patient began to have regular, rhythmic contractions every 5 to 7 minutes, lasting 25 to 35 seconds. She was admitted to the labor room at 7:00 p.m. with contractions every 3 minutes, lasting 20 to 40 seconds. The head was at the spines, in R.O.T. position, the cervix dilated 3 to 4 cm., and the baby estimated at 8 pounds. Sedation of morphine, ¼ grain, and scopolamine, 1/150 grain, was given at 9:30 p.m. at 5 cm. dilatation, and good relief of pain was experienced.

At 12 m. the membranes ruptured spontaneously. By 3:00 a.m. the patient was believed to be fully dilated; the head was 2 cm. below the spines in L.O.P. position. She was taken to the delivery room at this time to push with the pains. By 5:00 a.m., after 2 hours of good pains and voluntary effort, the head was on the perineum and a small amount of caput was visible.

The patient was routinely anesthetized by ethylene and oxygen, scrubbed, draped, and the bladder catheterized. Vaginal examination showed the membranes to be ruptured, the head on the perineum in L.O.P. position, and very slight molding present. The cervix was fully dilated.

A left mediolateral episiotomy was performed, and Kjelland's forceps were applied to the parietal surfaces of the fetal head by pelvic application. The head rotated easily in the pelvic midplane and was brought down without difficulty. The forceps were disengaged when the chin could be grasped by the modified Ritgen, and the delivery completed.

One c.c. of Ergotrate I.V. was given and the uterus contracted almost immediately. The placenta was expressed from the vagina three minutes following the delivery of the baby. The uterus seemed to contract fairly well following expulsion of the placenta.

As the episiotomy was being repaired a constant, heavy trickle of blood, estimated at 100 c.c. a minute, kept coming from the vagina, and the uterus repeatedly became boggy despite a repetition of the Ergotrate; 1 c.c. of Pitocin was also given intravenously. The vagina and cervix were felt for possible tears, but none were palpable. The repair was hurriedly finished in order that the anesthesia could be discontinued and the legs could be brought down. The pulse rate was then 140, the blood pressure 100/60, and an intravenous of normal saline was started.

For the next 10 minutes the blood continued to trickle unabatedly despite recovery from the anesthesia and repetition of the oxytocic. One thousand c.c. of plasma was started, the patient was cross-matched, re-anesthetized, and a careful search for the cause of bleeding other than an atonic uterus was started.

Under light ethylene anesthesia the vagina was inspected for tears, and none could be found. The cervix was carefully pulled down and inspected by direct vision, inch by inch; a small half-inch tear was found in the anterior lip, but it was not bleeding. The blood was issuing constantly from the internal os. The hand was inserted into the uterus, and all surfaces were carefully palpated for tears, but none could be felt, and no placental tissue was palpated. With the hand still in, 5 yards of 5-inch packing was inserted, the uterus was massaged, and some contraction was obtained, but within 20 minutes bleeding of a constant nature was noted from the vagina.

By this time the blood pressure had fallen to 60/20, and the pulse rate was around 160 despite a constant drip of blood plasma. A no. 16 needle was inserted into the vein of the other arm, and blood was started flowing as fast as it could run; a no. 18 needle was inserted into an ankle vein for another pint of blood.

Ergotrate and pituitrin were given at half-hour intervals, and at 9:00 a.m. Dr. J. J. Mundell saw the patient in consultation. At this time the patient was in moderate Trendelenburg position, receiving oxygen by means of a face mask. She was conscious at times. The bleeding continued at the same slow trickle. The uterus had ballooned up to half the distance between the umbilicus and the costal margin.

The uterus was then repacked, and was held and massaged constantly. In the meantime a steady flow of blood and plasma was kept up at the rate of 1 pint (average) every 15 minutes, normal saline being used to fill gaps when blood or plasma were not immediately available. A total was given of 5,000 c.c. of pooled plasma and 7,000 c.c. of citrated whole blood, type O, Kahn negative.

From 9:00 a.m. to 1:00 p.m. no definite change in the condition was noted. The extremities were pulseless, and the blood pressure could not be obtained. The heart rate varied from 160 to 180, and the patient was semiconscious.

At 1:00 p.m. the first spontaneous contraction of the uterus was felt, and at the same time moist râles were heard in the lung bases. The rate at which the drip was running was reduced, but pulmonary edema persisted. Fowler's position was instituted with immediate relief, and the râles began to disappear.

By this time the uterus could be felt to be definitely contracted, and within a few minutes bleeding was reduced to a minimum. The pulse could be detected within a short time, and by half an hour the blood pressure was 100/60.

The patient was placed in her own bed in Fowler's position. The oxygen mask was used intermittently, and morphine, $\frac{1}{4}$ grain, was given every 4 hours.

The following day the patient was in good general condition. The bleeding was normal lochia rubra, and she seemed perfectly normal except that she was unable to void and had small hiatuses of hallucination. She was started on sulfadiazine, 1 gram every 4 hours. The total output of urine was only 400 c. c. for that 24-hour period.

On the second postpartum day the hemoglobin was 53 per cent. The patient was mentally clear but still unable to void. A catheterized specimen showed bloody urine but no sulfadiazine crystals. The 24-hour output was 1,400 c.c., and the blood nonprotein nitrogen was 42 mg. per 100 c.c. Transfusion of 500 c.c. of citrated blood was given without reaction, and ferrous sulfate by mouth was started. Hot compresses to the perineum were applied 3 times daily.

On the third postpartum day the patient seemed much better but was still unable to void. She finally voided on the fifth postpartum day. She had been given a transfusion every other day, 3 in all. By the sixth postpartum day the hemoglobin was found to be 60 per cent, and the temperature was spiking daily to 103°F.

By the seventh day the patient was voiding, the temperature was normal, and the perineum appeared to be healing well.

She was discharged on the 15th postpartum day in good general condition, with a normal temperature, a hemoglobin of 73 per cent, and no residual urine.

DISCUSSION

The handling of this case was strictly routine. At least one definite error may be pointed out. In the excitement of finding transfusion and intravenous sets and getting the blood and plasma flowing into the patient, much time passed in which the uterus was not held and was allowed to balloon up into the abdomen. Once the uterus was held, this ballooning ceased, and the blood loss, although not completely checked, was probably materially reduced.

Other procedures than those utilized were discussed and dropped as impracticable. The patient rapidly became pulseless once shock developed, and any major operative procedure at that time, specifically hysterectomy, or even opening the abdomen to place clamps on the uterine arteries, would almost certainly have caused her demise. It is possible that application of clamps to the uterine arteries through the vaginal vaults would have stopped the bleeding, but this procedure was discussed only after the uterus and vagina had been packed the second time, and it was not thought worth while to disturb the packing.

The point of real value, however, is that without the large stores of blood and plasma available, and a definite amount that was immediately so, this patient could never have survived.

The expense of maintaining a blood bank makes it hardly worth while for a small hospital or one in which there is not a large daily turnover of blood. However, it would seem a reasonable line of procedure and no undue hardship on all obstetrical services to have immediately avail-

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President's Page

THE POWER OF AN IDEA

This past week, Holy Week, there have been hearings over on Capitol Hill on the Wagner-Murray-Dingell bill. Some of the medical profession who appeared before the Committee fared rather badly when they were questioned, a few did rather well, and one of the last witnesses on our side, Dr. Lowell S. Goin of California, made a brilliant witness and a most important showing for the medical profession.

Apparently all who heard him were tremendously impressed with how well he understood the problems of both compulsory and voluntary sickness insurance. I enjoyed him each time he was on his feet during the meeting of the AMA's House of Delegates in Chicago last December. I tried to pass on to the Society in my President's Page the following month how keen this California delegation were. Most of them were young men with tremendous drive and rare ability as speakers. Their intelligent, well planned efforts had defeated a plan in their state to put over a compulsory program for medical care. At that time this California group were keenly alive to the fact that what they had just averted in their state was about to be attempted on a national scale. With all the vigor they could command they endeavored to make all of us who attended the sessions see that the hour had struck and that the AMA must sponsor a nationwide health program if medicine was to carry on as it had in the past.

Someone has said, "There is nothing so powerful as an idea whose time has come." The public is clamoring for a health program, and this next week our Society will vote on whether it will accept or refuse to accept a voluntary prepayment plan. By the time this goes to print the question will have been settled and I have the feeling that the Society will vote favorably. It is not a full coverage plan and is not by any means perfect, but it has been most carefully worked out after a survey and analysis of several thousand hospital cases. The Committee on Medical Care has sat for hours and hours going over this data and have decided on fees which, although they may not please everyone, are as fair and equitable as could be arrived at after full discussion. We may have to change them if, after the plan has been in operation for sufficient time, the need for such change is indicated. Then too as soon as the plan has proved successful it can be broadened to include general medical care. The Committee thought the first effort should be to cover those sudden catastrophic illnesses which have caused such embarrassment to people in the past.

The profession all over the country, and Capitol Hill as well, know our Society is seriously considering this prepayment plan. It was our delegate, Dr. Coursen B. Conklin, who introduced in the House of Delegates the resolution that the AMA come out with a national health program, with emphasis on prepayment plans, which it adopted almost word for word. I do hope we will not disappoint them but continue to be leaders in this new venture.

Wm. Earl Clark

Editorials

DEMOCRACY AND MEDICINE*

The United States in a century and a half has become the greatest Nation in the world. George Washington, Benjamin Franklin, James Madison and their associates wrote the prescription in 1787. The treatment these statesmen and students recommended was composed of many ingredients. From a medical standpoint it might qualify as "a gunshot prescription." It contained the rights of the individual, opportunity for all, government by and for the people, freedom of religion, freedom of the press, freedom of speech, the right of peaceful assembly, and the right of speedy trial by jury. The vehicle for this prescription contained the inalienable rights of man to life, liberty and the pursuit of happiness and the fact that government exists by the consent of the governed. This prescription of economic vitamins changed the psychology of a group of people whose forebears had been regimented slaves in other countries, and in a century and a half made them the leaders of the world.

There are those who would throw away the prescription of democracy and substitute another remedy. The new cure is socialized medicine, political medicine or government medicine, and other federal controls.

That medical care is unavailable to all has never been proven. People do not die in the United States because of lack of medical care. A very small percentage of our population live more than thirty miles from a recognized hospital. The United States has more and better trained doctors and a wider distribution of medical talent than any other country in the world. Compulsory health insurance will not enhance the situation but will probably make good medical care more difficult to obtain.

Government control of medicine is the virus of national socialism, communism and dictatorship. Bismarck proved this in 1883 when he introduced social security and socialized medicine in Germany and brought forth in our time Hitler, Goering and Goebbels.

Medicine in America today is the best in the world. In our country we find the greatest hospitals, the finest clinics, the best teachers and clinicians, and the outstanding medical schools. Our health statistics are better than those of any other country and our death rate is lower.

Proponents of socialized or federal medicine or compulsory health insurance point to the number of rejections of prospective service men as an argument for government control of medicine in the United States. The rejection percentage of young men and women entering the armed forces was lower in the United States than in Great Britain or Germany, despite government medicine in those countries and the fact that our military requirements were the highest in the world.

Selective Service statistics reveal that 4,217,000 were disqualified for duty with the armed forces. It is, however, not pointed out that 2,707,706 were rejected because of defects which were congenital or over which no type of present-day medical knowledge could prevail! The remaining 1,509,294 are a group made up of many who refused scientific medical service because of religious or other beliefs; others refused minor surgical procedures because of the fear of induction. It is never pointed out that in this number there were All-American athletes, amateurs and professionals. No one bothers to advise the public that many could have been rendered fit for service by better health education, improved food, housing and living conditions, and other factors having nothing whatever to do with medicine. The great surgeons and the great clinicians and the many faithful and honest general practitioners of the United States of America should not be criticized for conditions over which they have no control!

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* This is the fourth in a series of guest editorials by distinguished physicians and laymen. Others to follow will deal with the scientific, social and economic aspects of medicine.

American medicine is in the front line of defense of the American Way of Life American Democracy. Medicine is opposing regimentation, not for its own sake but in the interest of business, industry and labor. When American medical men and women become government employees the path is cleared for political control of all endeavor and taps will have been sounded for the Constitution of the United States. It is very likely that when the people of America accept socialized medicine or government-controlled medicine, we are but a short step away from government newspapers, government radio stations, government insurance and centralized control of all endeavor.

There is no room in the United States for old world technics and foreign ideologies. These technics and ideologies have never been successful. We have been successful in the United States and we have become the greatest Nation in the world, although we are the youngest Nation in the world, because our Government has existed for the people and we have had no faith in the teachings of the old world that people exist for the government.

America has the best of everything in the world today. No other country can offer anything that compares favorably with American labor, industry, engineering, art, education, law, medicine or business. Why risk a change when no need has been demonstrated? It has been said, "Science prospers best when free." That there is no need for radical change in medicine is proven by the fact that 22,000,000 people have hospitalization insurance, 40,000,000 are insured in whole or in part against accident or illness, and an additional several million are participating in voluntary non-profit prepayment medical plans. These figures will probably double in the next six months. There are at present prepayment plans in 25 states and it is anticipated that such plans will be in operation in 15 additional states within a short period of time. Why endanger Democracy in America and overload the taxpayer when the American Way is extending to all the best to be offered in medicine today?

Let us always remember that our fathers came to America to be free and independent. Security depends upon independence. Let no one encourage dependency in "the land of the free and the home of the brave."

EDWARD J. MCCORMICK, M.D.
Chairman of the Council on Medical Service and Public Relations, American Medical Association

PSYCHOSOMATIC MEDICINE

We hear much nowadays of psychosomatic medicine. There is a journal devoted to it, also a society for research in the field. What does this new term signify, and what is its meaning for the internist or other specialist?

The term is awkward and open to various objections. Derived from the Greek words "psyche" or mind and "soma" or body, it denotes especially those problems of medicine in which physical symptoms have emotional causes, or at least emotional substrata. Although it is well to emphasize this relationship, the term implies that while there is a relation between mind and body there is a sharp difference of identity, a point of view to which the psychiatrist does not subscribe.

Certainly it is not a new thing to recognize that acute emotional experiences, such as rage or fear, have marked physiologic concomitants. The changes in pulse, blood pressure, secretions, and gastrointestinal function, to name only a few, are so common that they are part and parcel of our everyday language. The influence of emotion upon the autonomic functions is equally significant though less dramatic when it is less acute and brief. Every gastroenterologist recognizes that gastric ulcer or spastic colitis occurs with astonishing regularity in individuals of a certain emotional type, and the cardiologist recognizes a "coronary" type of patient.

The fundamental principle of "psychosomatic medicine" is a simple one, albeit one that underwent at least partial eclipse during the rise of specialism, and that is now being reëmphasized by the psychiatrist. It is that illness, of whatever nature, represents a failure of adjustment of the human organism to its environment, a failure which may occur at the structural, chemical, or social level. The functioning of the organism is important to the ability to get along with others; difficulty in getting along with others is equally important to the functioning of the organism. This truth has been borne in upon the medical officers who served in the Army and Navy, and a growing realization of the importance of the attitude implied in the term is well on the way.

Psychiatry has no monopoly of this field—far from it. It is a field which should be cultivated by all specialists and by the general practitioner. If a fuller recognition of the ailing person and his stresses can be secured, the rediscovery of an old and formidable term will not have been in vain!

W. O.

CANCER CAMPAIGN

While no data are available at this writing concerning the effectiveness of the National Cancer Campaign promoted throughout the country last month, some points should be made at this time.

Manifestly, the war on cancer cannot be left to just a month's campaign. The effort must be without letup until scientific research will discover for us means that will really bring prevention.

In the meantime, it would appear that we of the medical profession need to realize our responsibility more fully. The campaign to persuade the public to seek medical advice early obviously must be matched by the physician, who must deal competently and understandingly with the public. It is particularly with regard to the latter aspect that at least some of the profession need to improve their attitude. Both verbally, as well as by letter, the Department of Health has received complaints with regard to the reception received at some of the cancer clinics. Writes one of our correspondents, "I was told there, however, by one of the examining physicians, that they were set up to treat the disease and that unless I had good reason to believe I had cancer, I would not be examined."

Except for the fact that this correspondent writes an altogether intelligent and restrained letter, one would be disposed to brush off the complaint as just another fault-finding expression by a neurotic correspondent. Unfortunately, however, these complaints are not isolated experiences and that suggests that at least some of our professional brethren are lacking in understanding of dealing with patients as persons and not just "cases."

It will hardly do to urge the public on the one hand to seek medical advice and then turn away patients who have responded to such urging.

It is difficult to reconcile the professional appeal to the public to come for early diagnosis with the alleged statement that unless the patient has good reason to believe she has cancer, the physician would not proceed with examination.

It is fully appreciated that the curriculum of our medical schools is weighted down heavily with subjects believed to be necessary to prepare the student for the practice of medicine. Perhaps it is time that we revise our teaching courses and leave some of the technical matters to specialists and devote more time to training the medical student in practical psychology that would make him more sympathetic and more competent to deal with patients as human beings.

George C. Ruhland, M.D.
District Health Officer

MALIGNANCY—SHOULD THE PATIENT BE TOLD?

My answer to the question posed in the title is yes and no, with emphasis on "no." Like most controversial medical problems, this one is largely an individual decision between the physician, the patient, and the immediate family.

In general, patients facing the inevitable, with an incurable or inoperable malignant growth, should be spared, if possible, a mental cancer. Nature in her unfathomable way instills a sense of hope, out of all proportions to the known physical condition, in such unfortunate individuals. Here encouragement, coupled with appropriate sedation, seems the kindliest approach to one who lives by the old, old saying, "Where there is life, there is hope." Nature points the way; we as physicians can do no better than to follow her lead, to make the path as easy as possible.

It is a clinically accepted fact that many patients never ask the physician whether they have a malignant growth. They prefer not to face the reality, clinging rather to uncertainty with its ray of lingering hope. Where, however, a patient requests a definite answer, the physician may artfully evade the question; but if pressed, he may do well to explain the situation candidly.

In all cases, the physician is obligated to inform the nearest relative of any known malignancy, so that necessary steps can be taken for protection of the patient and family. This duty no physician should evade. Conversely, the physician has every right to rely on the immediate family for advice in discussing the true facts with the patient. The family may have special reasons, making it imperative that the patient be informed of his impending danger. One example is the individual who carries heavy business responsibilities. When for any reason it becomes necessary or advisable to inform a patient of his condition, the physician, in his understanding way, can best undertake this difficult assignment.

When a malignancy has been eradicated through surgery or X-ray therapy, patients should be told the facts without hesitation or evasion. The physician can state, with a degree of reserved confidence, that the disease has been removed. Actually, the situation is well known to the patient, insomuch as he has submitted to radical treatment, but he nevertheless needs assurance to carry him through. Having it in his power to give such assurance, the physician should instill in the patient that peace of mind essential to a confident human existence.

Daniel LeRay Borden, M.D.

In and Out of Focus

BY THE OBSERVER

Murray vs. Taft

There were varying opinions among regular attendants as to the manner in which Senator James M. Murray of Montana conducted hearings of the Senate Committee on Education and Labor on the Wagner-Murray-Dingell bill. To several observers he was more a pleader for the bill than a presiding officer. However, on one point all were in full agreement—the hearings got off to a noisy and rather violent start which, as it turned out, was most unfortunate for the proponents of this legislation.

It all began when Senator Murray in his opening statement referred to an editorial which appeared in the *Washington Post* decrying the practice of condemning programs for full employment, veterans' housing and health insurance as being communistic. The Senator observed it was "good advice to people not to be making charges that this measure [the Wagner-Murray-Dingell bill] is communistic." Senator Robert A. Taft of Ohio, a member of the Committee, took exception to this statement whereupon Senator Murray became highly incensed. Here is what happened as reported in the *Washington Post*.

> " 'Well, Mr. Chairman, if you're going to be partisan, I will too,' Taft remarked. 'I think this bill is socialistic . . .'
>
> " 'Now you keep quiet,' Murray warned angrily.
>
> " 'I think this bill is the most socialistic measure ever proposed seriously to the Congress,' Taft persisted. 'This committee is being run as a propaganda machine which will go on for a month . . .'
>
> " 'That's a slander and a falsehood,' shouted Murray, Chairman of the Senate Committee on Education and Labor.
>
> " 'You've shown your position,' Taft rejoined coolly. 'It's just a propaganda machine.'
>
> " 'It's people like you who have ruined progressive legislation by calling it communistic,' Murray countered. 'The Communists don't deserve such kudos. You're just reflecting your general conduct on the Senate floor here.'
>
> "Taft then asked permission to make a brief statement of his intention to submit an opposition health bill to the committee.
>
> " 'I don't care what you want to introduce,' Murray said, rapping his gavel.
>
> "Taft tried to continue but the Chairman shouted him down.
>
> "His dander up, the Republican Senator demanded to be heard.
>
> " 'I demand you subside,' Murray yelled back, shaking his fist at Taft. 'You've been impertinent and insulting.'
>
> " 'I intend to offer a complete bill . . .' Taft began again.
>
> " 'I don't care what you intend to offer,' Murray told him. 'You can shut your mouth up and get out. You're so self-opinionated and so self-important.'
>
> " 'Mr. Chairman,' Taft interjected, 'I move the committee adjourn until 10 a.m. tomorrow to give the chairman time to regain his temper.'
>
> " 'No,' said Murray. 'No, I won't adjourn. We'll go on as scheduled.'
>
> "Taft turned to the official reporter, 'I hope you're getting all this, because I intend to take it to the floor.'
>
> " 'Don't take it down,' Murray ordered the reporter.
>
> " 'You mean the chairman refuses to take down statements I make?' Taft demanded.
>
> "Senator H. Alexander Smith (R., N. J.) broke in to suggest that Taft be permitted to make his statement, but Murray refused.
>
> "Shaking his fist at Taft, Murray shouted:
>
> " 'I'm chairman of this committee and I want you to subside. If you don't shut up I'll get these officers in here to have you thrown out.'
>
> "An elderly Capitol policeman standing by the door looked straight ahead into space in an effort to make himself invisible as he faced the prospect of being caught in the middle of a Senatorial fight.
>
> "Some 50 or 60 spectators tittered, while a number of nuns interested in the legislation looked aghast.
>
> "Taft jumped to his feet and started for the door. He turned and shouted back:
>
> " 'I am leaving your committee and I shall not attend any more of its hearings. I think the country will know and the Senate will know that it is a completely one-sided, prejudiced, unfair committee.'

> "Raging, Murray retorted:
>
> " 'That's your general conduct, and you won't gain anything before the country by it. If you come in here and act like a statesman, all right. But you can't do that, no, you can't do that.' "

On the day following this outburst, the *Post* deplored the fact that its editorial had inspired such behavior. Editorialized the *Post:*

> "Senator Taft lit the fires of controversy, it is true, by resorting to the condemned labeling tactics and calling the health bill 'socialistic.' One thing led to another, the peppery and highly undignified interchange ending by Senator Murray telling Senator Taft to 'shut your mouth up and get out.' Fist fights occasionally occur on the floor of the House and Senate, but the principals in such encounters are usually hotheaded, irresponsible individuals whose antics amuse rather than distress spectators. There is nothing amusing, however, about the kind of wordy bout that led the chairman of the Committee on Education and Labor to threaten to throw out a member of the committee of the standing of Senator Taft.
>
> "It was an exhibition of bad temper altogether inexcusable. It was also a most unwise outburst, since the effort to suppress Senator Taft, who proposes to submit an opposition bill, strengthens his charges that the committee is run as a propaganda machine, 'completely one-sided, prejudiced and unfair.' In a democracy the labelers are entitled to criticize as well as to be criticized."

It seemed to your Observer wise under the circumstances for the medical journals to remain silent. However, the *Journal of the American Medical Association* in an editorial, "Senate Hearings on the National Health Program," appearing in the April 13 number, took a hand in the controversey. The *Journal* said, "The propaganda of Pepper, the diatribe of Dingell, the weasel words of Wagner and the modulations of Murray failed to find any expression in the public press."

Turning its attention to the new Federal Security Administrator, the *Journal* observed, "Amazingly Senator Murray several times referred to Mr. Watson Miller, the lay administrator who is responsible for health functions in the government, as 'Dr. Watson,' and apparently Senator Aiken was under the same misapprehension and also referred to him several times as 'Dr. Watson.' Presumably even the senators feel that health functions are properly problems for medically trained administrators."

At this point your Observer was prepared to make some sizzling remarks in his column. However, in the interest of all concerned decided against doing so. But he respectfully suggests that the *Journal* would do well to stick to the issues. There are ample and sound arguments for the medical profession's opposition to the Wagner-Murray-Dingell bill. Personalities have no place in them.

★

"...a Powerful Instrument..."

"In medical practice, knowledge of the patient's personality and social history is often essential for diagnosis and treatment. There is great need both in practice and teaching for well organized methods of obtaining this information. The interview is a powerful instrument if properly employed, yet most students and physicians have received little training in the art of interviewing."

Thus Dr. Clark W. Heath of the Harvard Medical School introduces his article, "An Interview Method for Obtaining Personal Histories," appearing in the February 21 issue of *The New England Journal of Medicine.* Claiming nothing new for his method, Dr. Heath says that it is "designed to reveal pertinent facts regarding the man's capacities, interests, personality traits, weaknesses and strengths," and that its use has "convinced me that an interview of this sort should be a part of the medical history."

As to the "how" of the interview, Dr. Heath explains:

> "The task in obtaining the personal history is not only to acquire a working knowledge of the personality of the patient, his activities and interests and his environment but also to establish a satisfactory physician-patient relation so that immediate therapy and future handling of the case will be facilitated. Much has been written about this sort of approach, which is the very core of the

practice of medicine. Monks in a pertinent article written in 1939 drew on the experience of Roethlisberger and his co-workers for practical suggestions in the technic of interviewing. The latter have pointed out that the interviewer is in the role of a listener, who 'should listen not only to what a person wants to say but also for what he does not want to say or cannot say without help.' A book by Bingham and Moore, entitled 'How to Interview' gives excellent material for the technic of various kinds of interviewing and describes their dangers and pitfalls.

"The interview is appropriately a part of the medical history. Brief questions are asked, giving the patient the opportunity to expand his replies. The approach is clinical, but it differs from that of the rest of the clinical history in an important respect. Whereas the usual clinical approach is to explore the range of possible diagnoses, the purpose here is to reveal positive traits and capacities and to discover what the patient does and likes to do and the nature of his background and adjustment, his way of life and his occupational and cultural environment. Some reorientation is necessary in the physician's thinking in acquiring this kind of information, for his training in history-taking, particularly if he has just completed his medical-school and hospital training, has been largely in the direction of identification of disease. The personal history serves a double function, since disabilities and defects inevitably come to light in the course of a well handled interview, and their nature can be pursued by appropriate questioning. Nevertheless, the main intent of the personal history should be to learn 'the whole nature of the man within the patient.'

". . . Competent interviewing is an art that is developed by experience. It is materially aided by a pertinent and thorough plan of the field to be covered. . . .

"It is a mistake to follow rigidly any definite order of questioning. Certain questions strike home in certain patients who, if they believe that they have a sympathetic listener, describe conditions of their life that are extremely revealing. In such cases, the order of the interview should be dropped for the time, the patient being allowed to pursue the point in question until the examiner is satisfied that a satisfactory understanding of the situation has been reached. The physician should be constantly alert to such possibilities. Here, as elsewhere, the advantage of the clinical method lies in its flexibility and its adaptability for different persons and changing circumstances. It has been observed that one must listen not only to what the patient says but for what he does not say. Often it is the manner in which a question is received and answered that is of importance rather than the actual content of the answer. To adopt the expression of Woods, 'The interviewer must depend upon the astute use of all his senses rather than upon systematized appraisal of question and answer.' Diagnosis in this field has not advanced nearly so far as has the recognition of classified somatic disease. Nevertheless, even in the latter field, reaching a diagnosis is often somewhat more of an art based on broad experience than it is a technic."

Dr. Heath outlines for the reader his conception of an interview which he says is likeliest to elicit revealing answers. Questions are listed under such general headings as Activities and Interests, Family Life, Religion, Occupation, General Habits, Mood, and Stability of Autonomic Functions.

Warning that the physician cannot "confine himself to his technological last without harming many patients," Dr. Heath says it "is surprising that the study of personality and environment forms such a small part of the teaching of medicine. It is as though this teaching were planned to train students for only half their probable duties as physicians—the more technological duties." However, he admits that there are understandable objections to proposals for spending time and effort in exploring the personal history of the patient. But these are more than offset, he insists, by the results obtained.

★

Voluntary Insurance Will Work

Proponents of a government system of medical care make a great to-do over the shortcomings of voluntary sickness insurance plans. Your Observer has begun to suspect that they are concerned lest they work. It is, of course, true that they have been very slow in developing. That, in your Observer's opinion, despite protests of medical leaders, has been largely the fault of organized medicine, which has not until the last year given the encouragement it should to their development. But to dismiss them as impractical and not a satisfactory solution for inadequacies in the distribution of medical care is certainly not justifiable. Nor can it be said with finality that it is not possible to make them comprehensive enough and that they will always be too costly.

Dr. Louis H. Bauer, a member of the Board of Trustees of the American Medical Association, recently gave one of a series of lectures on medical sociology at Harvard Medical School. In the course of his lecture he discussed voluntary insurance. Dr. Bauer said:

"The medical profession has accepted the principle of insurance as one of great assistance, but it continues to believe that such insurance should be on a voluntary basis to avoid political interference and to prevent the rendering of a mere quantity of medical care rather than care of a high quality.

"In the development of any new type of insurance, it takes time to make it successful and acceptable. At present all sorts of voluntary insurance plans are under experimentation. Some of the industrial plans date back twenty years, but many of them are of extremely recent origin. Many such plans that were started by medical societies have altered their method of coverage. Some of them have failed simply because they were not on a sound actuarial basis and were not organized to deliver good medical care.

"When the problem of insurance first came up, no one knew just what should be done. There was no actuarial background for any of these plans. No one knew how the public would react to the proposition or how physicians would react to it. Consequently, there was blind groping, but during the last four or five years a good deal of experience has accumulated showing some things that are good and some that are not.

"The American Medical Association has been severely condemned for not proposing a voluntary plan to cover the whole United States. To my mind, this would have been the surest way of killing the whole thing, for the very reasons just stated: no one was in a position to say what the best type of plan would be, and even now we are not entirely sure. It is my opinion that there never will be a single plan that is satisfactory for the whole United States, because a plan that will work in Missouri and Arkansas may not work in Massachusetts, what will work in the city will not work in the country, and what will work in agriculture will not necessarily work in industry. So that a variety of plans is needed, and I think that this will be the answer so far as insurance is concerned.

"There are persons who say that the voluntary plans will not work. Such statements are made in haste and perhaps maliciously—those who make them do not want voluntary plans to succeed because they prefer compulsory ones. Nevertheless, group hospital insurance, which is one form of voluntary insurance, has grown tremendously in the last few years. There are now over 19,000,000 persons in the United States who are covered by it. This is admittedly not enough, but in view of the increasing demand for this type of insurance, there is no reason why it should not be made available on a country-wide basis, and it probably will be. There are over 25,000,000 other persons who are covered, at least to some degree, by voluntary nonprofit medical society plans, industrial plans and commercial plans. These plans vary from complete medical coverage to coverage only for surgery and obstetrics, and from coverage for the whole family to that for workmen only.

"These plans must be made available to everyone who desires to be insured, and at a cost within his means to pay. Over half the states in the Union now have nonprofit plans, either in operation or in the throes of organization. Growth has been slow and will continue to be so, but it has been much more rapid in the last two or three years than anyone thought possible at the beginning. The public is not yet sold on the idea. There have been all sorts of surveys. They disagree on some points, but they all agree that the public is demanding some method of prepaying its costs for catastrophic illnesses, and the majority of the surveys state that the public prefers to do this on a voluntary basis if it can be so arranged. . . ."

"I have said that there are some persons who contend that voluntary insurance will not work, but it has not been tried long enough for them to make any such statement. One of the reasons given is that such insurance did not work in Europe. This is an unfair comparison, because in this country no voluntary plan that is worth anything has the slightest relation to any of the so-called 'lodge practices' or 'friendly societies' in Europe prior to the adoption of the compulsory program."

While your Observer cannot concur in the views expressed by Dr. Bauer with respect to the attitude of the American Medical Association in the past toward voluntary sickness insurance, he, like many others, is pleased that the Association is now prepared to lend its support to voluntary insurance.

★

Plea Falls on Deaf Ears

Are doctors being released from active military duty seeking reserve commissions? Offhand your Observer's answer would have been in the affirmative. It wouldn't have occurred to him that it could be otherwise. However, the other day he came across an editorial in the March number of the *Rocky Mountain Medical Journal,* entitled "Reserve Offers Fall on Deaf Ears" which brought him up short. "Official figures are not available to your editors," the *Journal* states, "but so far we have not heard of a single officer who has signed up. Counsellors at separation centers are required to ask each officer being 'separated' if he will please accept a reserve appointment and be sworn in at once. Refusals have been so vehement from each medical separatee that lately the counsellors have preceded the required question with personal if unofficial apologies."

What is the reason for this state of affairs? Here are those advanced by the *Journal:*

> "Nonprofessional use of physicians. Too many medical officers did little professional work or did none at all in their special fields. Paper work could have and should have been minimized for the doctor.
>
> "Nonprofessional commanders of professional men. Granted that most commanding officers of Army medical organizations and hospitals were themselves medical officers, their Regular Army status had made them purely administrators for years, regimented by regulations and without a stethoscope or scalpel in their hands since internship. Yet they often ordered skilled scientific men to 'do it the Army way' when scientific medical knowledge would rule differently.
>
> "Promotion policies. The Regular Army man always seemed to move up rapidly, deservedly or not. For A.U.S. medical officers, bootlicking seemed to be more effective toward promotion than certification by a specialty board.
>
> "Financial sacrifice. This is irrevocably tied to the promotion problem. In war everyone must sacrifice, but remember that the doctors volunteered. They left lucrative practices to do their part. Two or three years passed. The gray-haired doctor in his late forties, board diplomate, chief of a specialized section, in a large hospital, was still wearing captain's bars at a grand total of about $342.00 per month. Downy-cheeked boys who had yet to see the inside of a college but who could fly airplanes were wearing silver leaves or eagles on their shoulders, wings on their chests, and drew from $600.00 to $800.00 per month.
>
> "Sitting around. This was not alone a Medical Corps problem, but gross waste of medical personnel was one of the many tragic wastes of this war, especially when the shortage of doctors was acute throughout the civilian population and even in certain segments of the Army. We would like to learn the average time each medical officer spent sitting around in replacement pools, replacement depots and staging areas—just waiting for an assignment. Some of this was inevitable for in a great war, pools of every kind of man and materiel must always be ready for an emergency. But at least three fourths of it was pure waste, failure of distribution, faulty planning at the top.
>
> "If a similar emergency again befalls us—God forbid—we hope doctors will still volunteer and not have to be drafted. It would help insure the health of the future Army if real corrective action is taken now and is adequately publicized. The current crop of medical veterans would think more kindly of a War Department that publicly admits past errors and really moves to correct them."

★

Age in High Public Office

Middle age has its compensations. One would not think so to hear many people talk. How often we hear men and women congratulate themselves on how young they look, or they relate how they have been told that no one could guess how old they are. Now this is harmless enough, though sometimes rather boring.

Those who face life realistically, even those who "can't take it," should be much encouraged by the report appearing in the *Statistical Bulletin* of the Metropolitan Life Insurance Company for February. At least it proves rather conclusively that there are advantages to age. The *Bulletin* says, "There are striking instances of very young men in high public office, but they are the exception rather than the rule."

This observation was confirmed in a study reported in the *Bulletin* of the present age of chief executives of the various states. The youngest Governors in the country at the present time are 38 years of age. In this group are Governor Ellis G. Arnall of Georgia who was 36 when elected to office, and Governor John O. Pastore of Rhode Island, who moved up from Lieutenant Governor. Then there are Clarence W. Meadows, Governor of West Virginia, who is 41, and Governors Thomas E. Dewey and Horace A. Hildreth of New York and Maine, respectively, both of whom are now 43 years old.

But these "youngsters" are very much in the minority. For it is disclosed that "one third of the present Governors, 16 out of the 48, are under 50 years of age. Fifteen Governors, virtually another third of the total, are concentrated in the five-year age period 50 to 54 years. Of the 17 Governors who are beyond this age, only seven are 65 or older. The two oldest Governors are Walter E. Edge, of New Jersey, who is 72, and Walter S. Goodland of Wisconsin, who is 82. The average of the Governors of the 48 states as an aggregate is close to 54 years.

> "When one examines the age of Governors according to geographic division, marked differences become apparent. The lowest average age is found among the Governors of the New England States, where, it so happens, the average of the population is higher than in the country as a whole. The average age of the Governors of the New England States is 47.5 years; of the six, three are under 45. At the other end of the scale are the East South Central States, where the average—namely, 62.5 years—is higher than that for any other region, and 15 years above the average for the New England States. The other regions show no consistent geographic pattern with regard to the age of the Governors."

It seems that Democratic Governors are, on the whole, somewhat younger than their Republican colleagues, the average age being 52.2 for the first and 55.5 years for the latter. Part of this difference, the *Bulletin* explains, arises from the fact that the two youngest state executives are Democrats, and the two oldest are Republicans.

The *Bulletin* observes that there are at present no women governors. In fact, there have been only two in the history of the United States, Mrs. Miriam A. Ferguson of Texas and Mrs. Nellie T. Ross of Wyoming.

Thus it is clear that there are compensations in age and that only by acquiring years do we gain sufficient experience to warrant our holding positions of high trust.

★

Let's Break Down the Barriers

How often your Observer has heard doctors express their distaste for politics, medical or otherwise. Politics, in the minds of many physicians, is synonymous with evasion, subterfuge, and double-dealing. Of course, this is a distorted view and one it is to be hoped will be corrected.

Politics is defined by Webster as the "science and art of government." Obviously, then, society as we know it could not exist without politics, which, by the way, is not necessarily sordid. As a matter of fact, it is pretty much what we make it. Along this line the *Connecticut State Medical Journal* in its March number comments on the physician's relations to politics. The *Journal* says:

> "From the standpoint of performance American Medicine stands higher in prestige than ever before. The splendid war record in all fields of medical endeavor is one of common knowledge and in addition the average citizen is more aware that he is sharing benefits in health which are due solely to advances in scientific medicine. Nevertheless, in spite of these great accomplishments there still remains in a large group of our citizens a want of many of the benefits which medicine can offer. Our politicians are well aware of this as is amply witnessed by the number of legislative measures aimed at the extension of medical care which are before our national and state legislative assemblies.
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> "Medicine must recognize the fact that, whether it likes it or not, social reform along a wide front will not be accomplished without action on the part of our politicians. Without effort on our part it is futile for us to expect to be enacted only that legislation of which we approve and it is also futile for us to approach the political scene unless we come equipped with understanding and a spirit of coöperation.
>
> "The professional contribution of the physician to community life is indeed important but too often for his own good he has become detached from the political life of his community. In commenting upon the political decadence of one American city, Lord Bryce once declared that 'the most dangerous enemies of reform have not been the ignorant and poor, but men of wealth, of

high social position, and character.' Someone has recently said that intelligent people who refuse to share in the political life of the community may be considered 'civic conscientious objectors.'

"If we as physicians are to exert a wise influence on legislation aimed at extending medical care we must deliberately cultivate the friendship and confidence of those who make our laws and guide our political future. This interest on our part should extend all down the line to those citizens we elect to manage our local governments. One of the ways which would greatly enhance our position would be for more physicians to take an active part in community service not related to their profession. In our state we have a long tradition of the interest of the medical profession in political affairs and we will not forget that two Connecticut physicians, Lyman Hall and Oliver Wolcott, in 1776 signed the Immortal Document. Today many of our physicians are also carrying important civic responsibilities but we can and should do more. Perhaps we can look to our returned medical officers many of whom in their letters have shown a deep interest in political affairs."

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In the Cold Light of History

Since the first of the series of biographical sketches *Washington Physicians of Yesterday* appeared in the MEDICAL ANNALS, your Observer, upon whom has devolved the task of preparing them, has examined the biographies of many District physicians from Revolutionary times down to the present. From his reading, he has drawn some conclusions which may be of interest to present-day practitioners.

One fact stands out above all others, and that is that the physicians whose names loom large in local medical history were not necessarily those who were the most successful of their day. That is, many of them did not have large lucrative practices, although some did. Whatever fame came to them was due in a large part to their qualities of leadership, their foresight, and their recognition of the fact that, in the truest sense, they were servants of the people. Our physicians of today might well ponder their lives. If they prize above all financial success, they will simply be among the multitudes who are here today and forgotten tomorrow. There will be no niche however small in history for them.

On the other hand, the practitioner who sees how medicine can better fulfill its purpose in society and does something about it will not be forgotten. He may personally have many shortcomings. He may not even be as good a practitioner as his more successful colleagues. His personality may not be all it should be. Nevertheless, he has contributed something which has made the world a better place for his having lived.

In the April issue of MEDICAL ANNALS, Dr. Thomas Miller was chosen as one of the outstanding Washington physicians of a century ago. Dr. Miller was not too popular in his day, being disliked by many because of his insistence upon observance of ethics to the letter. In fact, he was considered to be rather unreasonable where professional behavior was concerned. An historian says of him that he was not a man of outstanding natural ability, but there was no doubt about his sincerity. Very active in public affairs, he was for a number of years President of the Board of Health of the District of Columbia.

Despite his personal shortcomings, Dr. Miller was deeply concerned with the welfare of the people and of his profession. He constantly sought to improve the public health and raise the standards of medical practice. He originated the movement to establish a system of registration of births and deaths in the District of Columbia, and was active in securing the establishment of St. Elizabeths Hospital. Thus Dr. Miller assured for himself an everlasting place in the medical history of the Nation's Capital.

There can be no doubt that many Washington physicians of former years would be greatly shocked if they knew what a small place they now occupy in history. Few of them indeed are of the select company of Dr. Miller and a handful of his colleagues. Many physicians may say that this is of no concern to them. But your

Observer does not believe it. It is natural for all of us to want to feel that we will be remembered because the world is a little better for our having lived.

Although he may be mistaken, your Observer believes that he can make a pretty good guess now who a few of the physicians of our time are who will loom large in the future. Some of their names would come as a shock to their confreres. A few of them may be thought of as bores and even quite ordinary. There are those, too, who are financially successful. But that makes little difference in the cold light of history. Time is a harsh judge but usually a just one.

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Our Veterans Have Changed

It will be recalled that during the war there was much talk about the adjustment veterans would have to make upon their return home. We were told by Red Cross and social workers who had been overseas that the problem would be a serious one. Veterans themselves resented the idea that they would be any different than when they left our shores. As it turned out, both were wrong. The "do-gooders" went entirely too far in their predictions and the veterans dismissed as inconsequential a problem with which they had not yet come to grips.

At any rate, physician-veterans like the others learned upon their return that there were adjustments to make. They discovered that they had changed more than they realized and that people at home were different. Somehow, too, returning to a way of life far removed from the regimented existence common to military organization was not the entirely happy experience they had anticipated. No longer was there a definite routine to be followed. Time was theirs to do with as they liked, but not for long, for they must again compete with their colleagues for a living. Fortunately a period of uncertainty and frustration for most of them did not last long. Sooner than he anticipated the physician-veteran was again "in the groove."

What are some of the things which the physician-veteran will carry over from his wartime experiences into private practice? Surprisingly, money is no longer as important to him as it was before the war. In fact, a good many returning physicians have told your Observer that making money is not their primary interest nor do they want to work as hard as they did formerly as civilian doctors. Life at best they say is very short. But they do want to practice better medicine and they intend to do so. It was heartening to hear them say these things. For it bodes well for the people when our physicians return home from the war with higher ideals than when they left to serve their country. Their genuine desire to render better service should make doctors everywhere proud of them. Certainly nothing justifies higher hopes for the future of medicine than this attitude of our physician-veteran.

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An Aid to the Press

One of the changes wrought by the war has been the disinclination of speakers appearing on scientific programs to prepare papers. Many of them insist they do not have the time to do so and unless permitted to speak extemporaneously decline invitations extended them. Even an abstract of their subject matter, they say, is out of the question.

This situation has become worse since V-J Day, aggravated undoubtedly by steadily increasing demands on the physician's time. Of course, the impossibility of obtaining such material makes it difficult to carry on a very important phase of medical public relations. That physicians themselves as well as the people are the losers is the point made by Don Morris in the *Philadelphia Record*,* who says:

> "Suppose you are appearing before one of these many meetings at The Philadelphia County Medical Society Building to talk before a professional association on the

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* Reprinted in *Philadelphia Medicine*, March 16, 1946.

effects of streptomycin. If your information is limited to your audience, you have failed to take advantage of a useful by-product.

"For if you really have something to say, the press wants to know about it, too. And, through the press, the public.

"The public desperately wants to know what you think about things. It has a right to know, too, a right to get its information from an authority instead of from gossip. It's the public's health that is at stake.

"Every time a member of the medical profession gives the public information of value, more public confidence in the profession is established. It's a part of public relations for the profession—and medicine never needed good public relations more than it does right now.

"Public relations, of course, are more than that. They are every little thing that is a contact with the public, including the way your secretary treats a timid stranger inquiring about an appointment. Not all of your public relations can be made smooth overnight, but it is so easy to win additional friends and influence more people by following through on your platform appearances that you shouldn't neglect it.

"Simply make an abstract of the talk you are going to give. Then see that it is in the Executive Officer's hands about three days before you are scheduled to talk.

"The Executive Officer will see that it gets to the press. If the press can work up something of reader interest from your abstract, it will. And the whole profession will benefit.

"Of course, it would be possible for a reporter to be at the meeting and listen to your talk. But then he has to rush back to the newspaper office to meet a deadline, and if there is anything not clear in his mind, it won't be clear in his story. Nor will he have time to ask you about it. Those possible pitfalls are avoided if the abstract is on hand in advance.

"It's not much extra work. And it pays off in big dividends in building public confidence in the profession through the long pull."

Your observer heartily agrees with Mr. Morris, and he hopes the time will not be too distant when more speakers can be convinced of the importance of their coöperating with their medical societies and the press in the manner he has outlined.

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Footnotes The British Medical Association, according to a United Press dispatch from London dated March 8, threatened to call a "doctors' strike" if the Labor Government's new public health system contained "objectionable" features. Commenting editorially on the then secret medical plan the *British Medical Association Journal* said that doctors would disrupt the public health machinery by refusing to work if the Government placed objectionable restrictions on private practice. The London *Evening Star*, a liberal newspaper, promptly retorted that the Medical Association represented a "die-hard element" among the doctors and was engaging in "what looks like obstruction." "Everyone sympathizes with doctors facing complete reorganization of their noble profession," the *Star* editorialized, "but most of them know that the old system is not in keeping with modern needs and that real state service must be evolved." There had been no suggestion that the Government's health bill would forbid private medical practice. Even if it did, the UP stated, there is evidence that the rank and file of members of the BMA may oppose the *Journal's* stand. Sixty-six per cent of the members participating in a recent straw vote approved of "group practice," and 60 per cent favored state medicine. A separate poll of medical students showed a large majority in favor of a state-supported health scheme. When the details of the plan became known late in March the BMA announced it was "unacceptable to the great majority of the medical profession." A meeting of the Association's delegates to decide what action shall be taken is scheduled for May 1. . . . A license has been granted by the Federal Communications Commission to the National Electronic Laboratories of Alexandria, Virginia to construct an experimental two-way radio station "for automobiles owned by doctors and nurses, and for taxicabs, ambulances, buses, public service trucks and other bona-fide carriers." The Medical Bureau Committee, at its last meeting, instructed the Secretary to ascertain whether it would be practical to make use of

(*Continued on page 250*)

PROPOSED VENEREAL DISEASE CONTROL PROGRAM

S. Ross Taggart, M.D.

Director, Bureau of Venereal Diseases, District of Columbia Health Department

It is my belief that the role of the private physician in the control of the venereal diseases is of paramount importance. Casting about in my mind for means of stimulating interest, in the least harassing manner, in routine examination for syphilis, regular reporting of venereal disease, and consistent interviewing of patients for contacts, I finally settled upon the program which I am now proposing. The problem as I saw it was to stimulate private physicians, as much as possible, in finding, treating and keeping under treatment an increasing number of persons with gonorrhea, syphilis and the other venereal diseases. It seemed to me that a short period of about forty-five days was as long a time as I could hope to interest any of you. During the period of May 15 through June, I propose to send you materials which I think might be useful to you in your routine examinations and treatment and which will, I hope, stimulate your interest in contact interviewing, morbidity reporting and routine examination for venereal diseases.

As, I admit frankly, an additional method of obtaining your interest, I plan the distribution of penicillin for ambulatory treatment of gonorrhea and hospitalization for penicillin treatment of primary and secondary syphilis. After consultation with officials of the U. S. Public Health Service they agreed to assist me in financing such a program and to assist in preparation of some of the materials. We shall have sufficient penicillin to furnish you 200,000 Oxford units of sodium penicillin for each case of gonorrhea you wish to treat. We have sufficient funds to permit for hospitalization and treatment of only 75 cases of primary and secondary syphilis. We are further limited in our payment for hospitalization of patients to not more than $5.00 per hospital day. We will furnish the penicillin to the hospital at the beginning of treatment or replace it at the termination of medication, whichever seems more satisfactory to the hospital in which you have your patient hospitalized. Perhaps I should say here that I do not feel it feasible to furnish penicillin routinely for free distribution and the department is only prepared to do so for the forty-five day period. The various hospitals have been contacted through their superintendents. Some have indicated they would be willing to receive cases of infectious syphilis. However, the possibility of your availing yourself of that part of our program referable to hospitalization will depend, naturally, on whether a bed can be made available for your patient at the time you wish to admit him. There is no objection to your patient occupying any price room he desires providing he pays the additional amount over $5.00 to which we are limited.

So far as penicillin for gonorrhea treatment is concerned, we have tried to make the distribution as easy for you as possible. We intend to poll you as to your wishes to participate in the program. If you indicate a desire to participate we will mail you six vials of penicillin and some morbidity report cards. We will replace your penicillin used on the basis of two vials (200,000 units) for each infected case reported.

So far as syphilis is concerned, when you have a case of primary or secondary syphilis and have been able to get a hospital reservation, if you will contact this office, National 6000, Extension 2165, we will mail or deliver to you a form with instructions for filling it out. One part of the form will serve as a voucher for hospitalization and one part may be retained for your files. Penicillin not to exceed 2,800,000 Oxford units and such arsenic and heavy metal as you may wish to use will be made available for each patient. Members of the Venereal Disease Department Staff will be happy to furnish you such consultative advice as they can.

You may well ask why we advise hospitalization and penicillin treatment, inasmuch as the best penicillin schedules to date have a relapse rate, serologic or clinical, of 15 per cent or more. If the same situation pertains in your private practice as does in clinic practice, and from my ten years' private practice, I must presume it does, the answer is easily perceivable. In 1945, of all patients admitted to the Rapid Treatment Center for penicillin treatment, only one patient left before completing treatment. Stated another way, then, if we treated

1,000 patients in the Rapid Treatment Center and our relapse rate was 15 per cent, 850 received curative treatment. During the same period, of our clinic patients coming to diagnosis with infectious syphilis only 48 per cent received a minimum of 20 arsenical and 20 heavy metal injections, and with a relapse rate of 5 per cent in those treated, we find only 455 receiving curative treatment.

I imagine that if you will review your patients from the standpoint of lapse from treatment before receiving a minimum of arsenic and bismuth, you will find somewhat the same situation in your own practice. I have abstracted the material on penicillin therapy presented at the meeting of the Office of Scientific Research and Development, February 7–8, 1946 and will mail that to you at a later date, together with the experimental schedules which the Office of Scientific Research and Development is now investigating, and in addition the schedules being investigated by the U. S. Public Health Service.

Contact interviewing as a method of breaking the chain of infection of which each diagnosed patient is a link may be in some cases better carried out in your office and in other cases better carried out by the Venereal Disease Bureau. We intend sending you materials on contact interviewing and epidemiologic procedures applicable to venereal disease control.

In brief, a program for coöperation of private physician and Health Department in a venereal disease program from May 15 through June 1946 is presented. Routine examination, contact interviewing and morbidity reporting will be stressed. Educational material for distribution to your venereal disease patients and free penicillin for treatment of gonorrhea and primary and secondary syphilis will be furnished.

REPORT OF THE EXECUTIVE BOARD ON PREPAYMENT PLAN*

As you know, this meeting has been called for the purpose of considering the adoption of the prepayment medical plan developed by the Medical Society's Committee on Medical Care. In view of the importance of this matter, your Board deems it advisable to go into considerable detail not only with respect to the proposed plan but to the historical background of prepaid medicine. The Board hopes that you will be patient despite the length of this report because no decision our Society has been called upon to make in recent times has been of such far-reaching importance as the one it is asked to make tonight.

It is to be hoped that most of our members, and certainly most of you who are present this evening, have read the communication and the pamphlet sent you by the Committee on Medical Care describing the limited prepayment medical plan to which the Committee has given the name MEDICAL SERVICE OF THE DISTRICT OF COLUMBIA. . . .

The Board is anxious that each one of you fully appreciate the significance of the proposal made and the obligations it places not only on the Society as an organization but on all those who compose its membership. Without an appreciation on the part of our members of what is involved and a willingness to do their part, the plan cannot possibly succeed and should not be undertaken.

The material described above setting forth some of the background and describing the proposed plan was sent to the membership on March 2. Ample time has therefore been given all members to study the program contemplated. As you will recall, each member was asked to indicate whether he approved or disapproved the plan, and to offer such criticisms and suggestions as he wished. On April 4, 369 had replied, of which 10 were opposed and 8 declined to state their opinions. This, however, tells only a part of the story, for about 30 per cent of those who responded had suggestions or criticisms to offer. These will be considered later in this report. For the time being, the Board wishes to make it clear that it in no sense considered the replies received by the Committee a vote for the adoption of the plan. The Committee sought merely an indication of the acceptability of its proposal and such comments as individual members cared to make. The latter, it believed, would be most That the helpful. Committee's decision was a wise one is shown by the fact that nearly a third of the members responding gave it the benefit of their views. Then, too, the response demonstrated that a substantial portion of the membership sensed the importance of the proposed project. In fact, many of them asked that there be no further delay in sponsoring a prepayment program. A few thought it was already very late to do so.

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* Presented to the Medical Society at a Special Business Meeting, April 24, 1946. Action on this report was held in abeyance for two months pending hearings to be held by the Committee on Medical Care. The purpose of these hearings is to afford all members an opportunity to discuss with the Committee all features of the prepayment medical plan submitted.

OUR SOCIETY'S PAST ACTIVITIES IN PREPAID MEDICINE

If we are to appreciate fully the present situation which confronts the medical profession in the District of Columbia, we must turn back the pages of time some seven or eight years. Although our Society has been deeply interested in the subject of prepaid medicine for nearly two decades, it did not attempt to invade the prepayment field until 1939. However, projects such as the Medical-Dental Exchange and the Central Admitting Bureau were undertaken some years before. But the agitation within and without the profession for a prepayment plan came to naught until MUTUAL HEALTH SERVICE, a full coverage prepayment plan, was sponsored by the Society.

Many reasons have been given for the failure of MUTUAL HEALTH SERVICE. The truth is that it was due not to one but a combination of factors, among them the legal proceedings in which the Society was engaged because of its difficulties with Group Health Association, Inc., and the resulting antagonism of the Government departments; restrictions on those who could participate in the plan based on income levels; and its comparatively high premium because of the complete coverage contemplated. Despite the most strenuous efforts on the part of its director, MUTUAL HEALTH SERVICE's existence was terminated for lack of support six months after its establishment.

There were those who felt that despite this experience another plan of a more limited nature should be offered the public immediately. However, there was a lack of enthusiasm in the Society for the undertaking, and not too long thereafter our country was engaged in a World War. More than one third of our physicians responded to the call to serve with the armed forces, the result being that medical personnel in the District of Columbia, like many other communities, was considerably depleted.

Despite these conditions, there were those in the medical profession who questioned the advisability of delay. For they realized that it was only a matter of time until the Society again would be confronted with the necessity of considering a prepaid medical plan. Nevertheless, there was slight possibility of doing anything about this matter during the War for toward its close there was approximately one physician to 1,250 inhabitants in the Washington Metropolitan Area, this being the minimum ratio if the people were to receive essential medical care. However, in the spring of 1944, the then President of the Society, Dr. James N. Greear, Jr., decided to recommend to the Executive Board and the Society the reorganization of the Committee on Medical Economics, which later became the Committee on Medical Care. The present Chairman, Dr. Frank D. Costenbader, was appointed with the request that he and his Committee begin work on a prepayment medical plan, an assignment which has been faithfully carried out.

During the two years prior to V-J Day, Dr. Costenbader and the Secretary of the Society made a first-hand study of two prepayment plans, Michigan Medical Service and the Hospital Savings Association of North Carolina. The latter provides not only hospitalization but surgical and maternity care. Some months after he took over, Dr. Costenbader arranged conferences with representatives of Group Hospitalization, Inc., recognizing the importance of efficient business administration of any contemplated plan, and the assurance of success if Group Hospitalization's active coöperation were obtained. These conferences continued over many months. Finally there were encouraging indications of this organization's interest, and with its help a study of some 10,000 hospitalized cases was made for the purpose of arriving at actuarial figures.

It was agreed in the beginning by representatives of the Society and Group Hospitalization, Inc., that the most desirable plan would be of the "service" variety. It might be explained here to those who are not familiar with prepayment plans that there are two kinds of plans, service and indemnity. Under the service plan, medical care is guaranteed. The indemnity plan indemnifies the participant in cash according to his disability and the amount the plan agrees to pay. It may or may not cover the service he needs. The amount paid him merely applies on the costs of the service rendered him. This is the type of plan sponsored by private insurance companies and also by some medical organizations.

The Committee favored the service plan for many reasons. First, it gives the greatest promise of success. Then, too, it is acceptable to Group Hospitalization, Inc. Indications are that the Government also looks with greater favor on this type of program. Needless to say, that is very important. Furthermore, it could be incorporated under the laws of the District without regard to insurance laws, whereas the opposite would be true of the indemnity plan. The indemnity plan would necessitate capitalization far beyond the means of the Society. Of course, if such a plan were decided upon, the Society could seek enabling legislation, that is, passage of a law which would permit the Medical Society of the District of Columbia to establish an indemnity plan without the capitalization ordinarily required. This has been done in a few states but would be nearly impossible in Washington, because many on Capitol Hill would oppose such legislation if for no other reason than that it would be setting a precedent for the Nation. At any rate, for these and other reasons, your Committee decided upon the service plan which the Executive Board is submitting for your action tonight.

Mention should be made here of the conferences held during the war by the Committee on Medical Care with leading citizens of Washington, the purpose being to ascertain their views with respect to prepayment plans. Discussions were also held by the Secretary with editors of all Washington newspapers. All favored the Society's undertaking a prepayment program. In fact, most of them urged it strongly.

As most of you know, the Secretary of the Society communicated regularly with all of our members in the Services. In one of his newsletters, dated June 27, 1945, he endeavored to ascertain their views on prepaid medicine. With only one exception, those who replied urged that immediate steps be taken to inaugurate a plan.

What Has Happened Nationally?

No picture of what has occurred locally would be complete without something being said about the national situation. Ever since the Committee on the Costs of Medical Care completed its exhaustive study in 1932, there has been agitation for a Government system of medical care. This Committee expended hundreds of thousands of dollars in an investigation of medical services in this country. The conclusions arrived at by the majority of the Committee were violently opposed by the medical profession. Ever since, the controversy has mounted in fury. Not only have compulsory health insurance bills been introduced year after year in many states of the Union, but in the Congress itself there has been much health legislation objectionable to the medical profession. You are all familiar with the series of bills sponsored by Senators Wagner, Murray and Dingell, and that hearings are now being held on the latest version by the Senate Committee on Education and Labor.

While no compulsory health insurance bill has been enacted by any state, nor are there any indications that the present Wagner-Murray-Dingell bill will be passed, one cannot escape the conclusion that the proponents of radical changes in medical practice are gaining rather than losing ground. The fact that the present Wagner-Murray-Dingell bill may go down to defeat should not make physicians too confident of the future. As a matter of fact, the present hearings, according to observers, are tending to influence greater numbers of our people in favor of a Government system of medicine.

How is the American Medical Association meeting this situation? Certainly the Association has been handicapped because of its failure in the 1930's to appreciate fully the strength and the tenacity of proponents of compulsory health insurance. However, down through the years it has consistently and successfully, too, fought the proposals made by advocates of Government medicine. Some years ago it began to dawn on Association leaders that this could not go on indefinitely; that there was a need for better distribution of medical care; furthermore, that health, or more accurately, sickness insurance, was a medium through which this could best be accomplished. Finally, the insurance principle was accepted by the Association, first in indemnity form, and later approval was given the service plan. However, little was done by the Association until the last year to bring about the establishment of voluntary sickness insurance plans. Several state medical societies, among them California, Colorado, Delaware, Massachusetts, Michigan, Missouri, New Jersey, New York, North Carolina, Oregon, Pennsylvania, Texas, Washington and West Virginia, went ahead on their own initiative. At the present time there is hardly a state society which does not have a plan in the process of formation.

With the advent of the Truman Administration it was thought by many physicians that the pressure for changes in medical service sought by his predecessor would be lifted. However, the contrary proved to be true. President Truman went much further in his demands than President Roosevelt. He called upon the Nation last November to enact legislation providing for a compulsory health insurance program. Immediately after his message had been delivered, a new Wagner-Murray-Dingell bill was introduced. This was quite a shock to medical leaders who then realized that immediate action was necessary unless the profession was prepared to let the Government do the job.

Early in December of 1945 at a meeting of the House of Delegates of the AMA, an historic step was taken when a report was adopted committing the AMA to the development of "a specific national health program, with emphasis on the nationwide organization of locally administered prepayment medical plans sponsored by medical societies." This verbiage is nearly identical to that contained in a resolution drafted in Washington and introduced in the House by Dr. Coursen B. Conklin, Delegate to the AMA from the District of Columbia. Thus, the AMA is now committed to establish prepayment plans in every state and the District of Columbia. It is clear, therefore, that each jurisdiction has placed upon it the responsibility of developing a prepayment plan and placing it in operation at the earliest possible moment.

Fundamentals of Plan Proposed

In the light of this background, let us proceed to consider the prepayment medical plan, Medical Service of the District of Columbia, being submitted for your consideration tonight.

In the first place, it is a limited prepayment medical plan providing only for surgical and obstetrical services, supplemented by X-ray, laboratory, and anesthesia services *in the hospital* to subscribers to the SERVICE. The plan's objective is to spread the costs of catastrophic illness so that they will not be a burden to any individual. Here it should be mentioned that expansion of services provided by the plan to include medical as well as surgical, obstetrical, X-ray, laboratory, and anesthesia services in the hospital are contemplated "if and when conditions warrant."

In reading the description of the plan, it is to be noted that there is free choice of physician, providing the physician chosen has agreed to participate in the SERVICE. Likewise the participating physician can choose his patients among subscribers.

As to its organization, the SERVICE consists of physician-members of the Medical Society who volunteer to become participants. The SERVICE, it is contemplated, will be incorporated under the laws of the District of Columbia. A Board of Trustees shall be responsible to the membership for the conduct of the SERVICE. The personnel of the Board would consist of the following: a member nominated by the United States Public Health Service; two members nominated by the Washington Metropolitan Health Council; a member nominated by the District Health Department; and seven members nominated by the Medical Society of the District of Columbia. The Secretary of the Medical Society of the District of Columbia would be an ex officio member of the Board of Trustees without a vote.

Operation of the SERVICE proposed shall be the responsibility of its Board of Trustees. However, the Board may contract with Group Hospitalization, Inc., to administer the plan under such terms and conditions as may be agreed upon. The desirability of such an arrangement is emphasized because of the success of Group Hospitalization, Inc., which is firmly established with more than 360,000 subscribers, or approximately one out of every four persons in the Washington Metropolitan Area.

A Committee on Physicians' Services will review and approve payment of bills other than those of a routine nature submitted by physicians for services rendered to subscribers, and review and adjudicate complaints involving patients and physicians. Appeal may be made from decisions of the Committee to the Board of Trustees, whose decision shall be final. The Committee will be composed of three members of the SERVICE appointed by the Board of Trustees for the term of one year.

It is recommended that the cost of services which a subscriber shall receive in any one year shall not exceed $300 per single person, $400 per husband and wife, and $500 for a family. As in all plans, there are limitations and exclusions. For example, there is what is called a "waiting period." In other words, no subscriber is entitled to obstetrical care or such operative procedures as tonsillectomy, adenoidectomy, herniotomy, and hemorrhoidectomy for the first ten months. Nor is he entitled to treatment for conditions known to exist at the time of application.

Subscribers are accepted only in employed groups, and 50 per cent of all eligibles in any such group must subscribe to be accepted.

Subscribers' dues were determined after a careful analysis of Group Hospitalization cases in one of its peak years. It was found that services promised in the plan could be provided for a single person at 75 cents per month, subscriber-spouse at $1.50 per month, and subscriber-spouse and dependents at $1.75 per month.

Active, Life and Associate members of the Medical Society may render service under the plan. As previously stated, any participating physician reserves the right to decline to render service to a subscriber, and a subscriber in turn is privileged to discharge a physician in the same manner as is now done in private practice.

As members are fully aware, a vital aspect of the plan is its schedule of fees. It is also the most controversial because there are varying opinions as to what constitutes a fair schedule. When considering the schedule, members should keep in mind that (1) fees are of necessity moderate in view of the average income of the group served; (2) there will be no losses or collection costs, which should more than compensate participating physicians for somewhat lower fees to certain subscribers; (3) participating physicians are permitted to charge fees which they consider fair where subscribers demand luxury hospital accommodations; and (4) fees will be paid for some persons usually treated in the public clinics and wards.

Although subscribers are accepted only in employed groups, some restriction, it was felt, should be placed on those for whom the plan would pay the full cost of the service received, the reason being that there might be some, though comparatively few, who were capable of paying larger fees than the schedule called for. Income level restrictions are not recommended in this plan because (1) they helped cause the failure of MUTUAL HEALTH SERVICE, (2) they are not acceptable to Group Hospitalization, (3) they make more difficult the "selling" of the plan to employers, and (4) they place upon administrators of the plan the difficult task of ascertaining incomes of subscribers.

Obviously another method had to be developed. As a result of the Committee's deliberations, the following provision was decided upon:

"The fees listed . . . will be considered full compensation for services rendered except where subscribers demand non-

essential hospital accommodations. 'Essential hospital accommodations' shall be defined as a private room for which a charge of not more than $8.50 a day is made (this figure may be revised upward or downward by mutual agreement of the Board of Trustees of MEDICAL SERVICE *and Group Hospitalization, Inc., as experience and judgment demonstrate its soundness). Where the subscriber demands a room for which a charge of more than $8.50 a day is made, the fees below need not be considered as being a full payment of the physician's services. In this event the physician and the subscriber will agree on a charge for the services rendered, and the fees listed below will be applied on the physician's bill.*

"The above provision relating to 'non-essential accommodations' will be nonoperative in all cases where essential rooms are not available; also, when an attending physician himself determines that an emergency exists and recommends that the provision for extra charges be suspended."

Perhaps the largest number criticized the exclusion of general medical service or their particular specialty. The Committee would very much like to include medical care in the hospital but thought it advisable to begin with a limited plan such as has proved successful elsewhere. Medical service, it promises, will be included as soon as possible.

In this connection, your Board recommends that a committee be created for the purpose of studying the possible expansion of MEDICAL SERVICE to include other services. It is true that patients suffer catastrophic costs of illness aside from those involving surgery and obstetrics. But an opportunity must be given the plan to evolve to a point where it is financially sound before expansion can safely take place.

And here mention should be made of the general practitioner. Criticism has been leveled at the plan because there is no place in it for him. This is, of course, not true. If he is eligible to do surgery and/or obstetrics in a class A hospital, he can become an active participant in the plan as proposed.

CHART 1

Private Room Accommodations

CHARGE PER DAY	CASUALTY	CHILDRENS	COLUMBIA	DOCTORS	EMERGENCY	EPISCOPAL	GARFIELD	GEORGETOWN	GEORGE WASHINGTON	PROVIDENCE	SIBLEY	TOTAL
	Number of beds											
$8 or less	16	0	20	0	20	12	69	69	13	43	100	362
Over $8 to $10	5	36	26	54	36	14	53	9	18	4	3	258
Over $10	0	0	8	96	18	2	22	0	0	1	0	147
Total	21	36	54	150	74	28	144	78	31	48	103	767

Several have informed the Committee that, in their opinion, the $8.50 limit is too high. Before this figure was decided upon, a survey was made of all hospitals with the following results (see chart 1).

It will be noted that two thirds of the private room beds in Washington hospitals are above $8.00, which should allow for the charging of additional fees to those who demand more expensive accommodations. You will, of course, keep in mind that costs of hospital accommodations are increasing, which will have the practical effect of lowering the limit set forth in the plan. Your Board believes this is as satisfactory a method as can be devised at this time.

FURTHER SUGGESTIONS AND CRITICISMS

As stated previously, 30 per cent of those who returned the forms sent them by the Committee on Medical Care, on which to indicate their approval or disapproval of the plan, had comments to make. Some of them were in the form of suggestions. Others were mildly to severely critical of various features of the plan.

The question has arisen whether laboratory facilities will be available to patients with surgical conditions if the diagnosis has been made by a general practitioner. The answer is "Yes," providing the patient goes to surgery.

Another criticism leveled at the plan is that certain surgical operations can be performed in an office as well as in the hospital and that to require patients to be hospitalized regardless of this fact would create pressure on already overcrowded hospitals. In answer to this criticism, your Board would again call attention to the fact that the plan is still in its early stages of development, that it must be limited at the present time to surgery and obstetrics in the hospital until its financial stability is assured. The Board recommends that another committee be created to consider the inclusion of certain office procedures.

Not a little criticism was directed against X-ray and laboratory fees. Your Board is pleased to report that the Committee has communicated with representative groups of practitioners in each field. The Committee has just been informed that several items appearing in the X-ray fee schedule have been reduced to the level of the Workmen's Compensation Schedule. Consideration is also being given to the revision of its fees by the Section on Pathology and Laboratory Medicine.

Of course there were those who did not feel that the fees listed were high enough. However, as has been explained, the fees were arrived at only after consultations with individuals and groups in the various fields. The Committee believes that they are fair considering the group to be served. One thing must be kept in mind, and that is that should general economic conditions warrant, they can be revised. This, in your Board's opinion, should be understood by all parties to the plan.

There has also been the criticism that the fees cover only the services rendered in the hospital and permit too much latitude for extra charges for services outside the hospital. It would reflect no credit on the medical profession if advantage were taken of this situation by participating physicians. Your Board cannot believe they will do so.

Finally, the complaint has been made that the name of the plan, Medical Service of the District of Columbia, does not reflect its true scope. The Committee expected this criticism but decided nevertheless to retain the name because it fully intends to include general medicine as soon as possible. It would be a disadvantage to have to change the name of the plan at that time. After all, surgery and obstetrics are the practice of medicine, and the publicity in connection with the program will be such that those who consider subscribing will not be misled.

Arrangements Which Must Be Made

If the Service as presented and modified is adopted by the Society, conferences will follow immediately with officials of Group Hospitalization, Inc. These officials have already indicated that they are favorable to the plan. In fact, there is little doubt in the minds of the Committee that satisfactory arrangements can be completed for the establishment of the plan within a very short time.

The question then arises as to the financing of the plan in its early months of existence. This will require about $5,000, which would be in the form of a loan from the Society to be repaid as soon as the Service is financially able to do so. The Society has at present sufficient funds to make this loan providing it meets with the approval of the membership. If you approve the plan, it is understood that you are agreeable to the Society's making this loan for the purpose of establishing the plan, and entering into an agreement with Group Hospitalization, Inc., for the purpose of administering the business affairs of the Service. In regard to the latter, this means handling subscriptions, keeping all financial records, "selling," and, in general, managing all but the medical aspects of the plan.

All arrangements would be completed by the Committee under the direction of the Executive Board.

Conclusion

As stated in the beginning, your decision with respect to the plan submitted to you is a momentous one. There is no doubt in the minds of your Board as to the course the Society should pursue. It believes that considering the action of the AMA and the majority of state medical societies, our Society has no alternative. Either it sponsors a medical prepayment plan or someone else will. But let it be understood that this plan is not being advanced as a defensive measure. Your Board and Committee sincerely believe it fills a real need.

Your Board is certain that the plan submitted is not perfect. In fact, it should be clearly understood that it will require careful administration and that the elimination of defects and expansion will take a considerable period of time. It is, nevertheless, confident that in voting to undertake this plan, the Society will be making no mistake. In fact, it will be taking a progressive step which can only win for it public approbation.

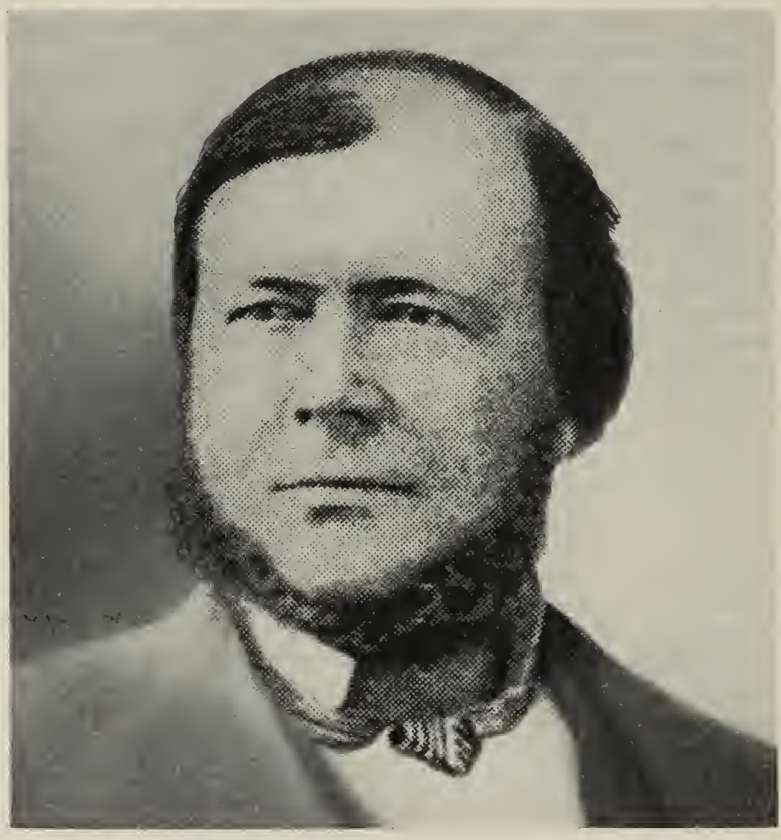
How important this step is, is emphasized by a statement made by Senator Wayne Morse of Oregon at a hearing on the Wagner-Murray-Dingell bill last week. The Senator is a friend of the medical profession and solicitous of its welfare. On this occasion he said:

"I have yet to be convinced of the merits of all the features of the so-called Wagner-Murray-Dingell legislation, but I have said at the medical meetings, and I say here now, that I think the medical profession has got to go much further than it has gone yet to see to it that adequate medical care is given the masses of our people, large segments of which do not get it now. It is a great citizenship service they can perform if they really want the profession (to have) a private property economy."

Finally, then, the Board recommends the approval of the prepayment medical plan to be known as Medical Service of the District of Columbia and that its immediate establishment be authorized in the manner previously described.

Respectfully submitted,
Henry R. Schreiber, M.D., *Chairman*
William M. Ballinger, M.D.
William Earl Clark, M.D.
Coursen B. Conklin, M.D.
William P. Herbst, M.D
A. M. MacDonald, M.D
Fred R. Sanderson, M.D.
Theodore Wiprud, *Secretary*

Washington Physicians of Yesterday



ROBERT KING STONE, M.D.

Dr. Robert King Stone enjoyed the distinction of being physician to President Abraham Lincoln. In his day he was one of Washington's leading physicians, highly thought of by his colleagues and popular in the community. Dr. S.C.Busey, in his "Personal Reminiscences," speaks of Dr. Stone as being "broad-minded, open hearted, generous and forgiving man, who met everybody with cordial greeting and salutation which . . . spread all around and about him the mellow radiance of a soul that was most happy when making others happy." He was in considerable demand as a speaker, being fluent and very much at ease on the platform.

Born in the District of Columbia in 1822, Dr. Stone received his early education in the place of his birth. He attended Princeton University where he received his Bachelor of Arts degree in 1842. His degree of Doctor of Medicine was obtained at the University of Pennsylvania in 1845. After graduating from medical school he attended clinics at hospitals in London, Edinburgh, Paris and Vienna, paying special attention to diseases of the eyes and ears. At one time he was a special pupil of Desmarres.

Returning to Washington in 1847, he began practice, a year later being appointed Adjunct Professor of Anatomy and Physiology at Columbian Medical College. Subsequently he became Professor of Ophthalmic and Aural Surgery. Due to a fracture of the thigh, he gave up "outdoor practice."

In 1849 he married the daughter of Thomas Ritchie, who founded the *Richmond Enquirer* in 1804, and the *Washington Union* in 1845.

Dr. Stone was actively interested in civic affairs. He was President of the Board of Health in Washington from 1858 to 1861. He died in Philadelphia on April 23, 1872.

Military Affairs

SERVICE PHYSICIANS RETURNING TO WASHINGTON

In the August 1945 issue of the MEDICAL ANNALS names of the members of the Medical Society who had returned to civilian practice were published with a brief description of their war service. The number who have returned to civilian practice since then is now so great that it is impractical to include a brief summary of the war service of each individual. Listed below are the names and addresses of those who have returned since the last list was published.

Arnold A. Albert, 2713 Wisconsin Ave., N. W.
John J. Andrina, 1801 Eye St., N. W.
Ellis April, 1530—16th St., N. W.
Louis B. Bachrach, 1726 Eye St., N. W.
William E. Bageant, 6305—7th St., N. W.
John G. Ball, 7936 Georgetown Rd., Bethesda, Md.
Henry L. Bastien, 3260 Wilson Blvd., Arlington, Va.
E. Herbert Bauersfeld, 17 Dupont Circle, N. W.
William H. Beard, 2814 Connecticut Ave., N. W.
Montgomery Blair, Jr., 84 Kalorama Circle, N. W.
Abe Blajwas, 1915 Kalorama Rd., N. W.
Thomas Bradley, 1744 N St., N. W.
Alfred E. Brigulio, 1422 Taylor St., N. W.
Brooks G. Brown, Jr., 1835 Eye St., N. W.
Peter P. Brue, 4343 Davenport St., N. W.
Warren B. Burch, 208 Maryland Ave., N. E.
Everett S. Caldemeyer, 1826 R St., N. W.
Ralph M. Caulk, 1835 Eye St., N. W.
John R. Cavanagh, Georgetown University Hospital
Morris Chase, 2902 Porter St., N. W.
William W. Chase, 1801 Eye St., N. W.
Austin B. Chinn, 5010 Sedgwick St., N. W.
Thomas Christensen, 6905 Baltimore Blvd., College Park, Md.
Milton C. Cobey, 1835 Eye St., N. W.
Robert J. Coffey, 1150 Connecticut Ave., N. W.
Roger S. Cohen, 1610 Eye St., N. W.
Francis T. Coleman, 1323 Kennedy St., N. W.
Aloysius J. B. Connolly, 1635 Irving St., N. W.
Karl C. Corley, Georgetown University Hospital
Darrell C. Crain, 1150 Connecticut Ave., N. W.
Allen S. Cross, 1100 Pennsylvania Ave., S. E.
Ralph Crowley, 229 East 79th St., New York, N. Y.
Horace H. Custis, Jr., 1852 Columbia Rd., N. W.
Alfred A. J. Den, 3500—14th St., N. W.
Jack L. Derzavis, 900—17th St., N. W.
Robert H. Detwiler, 3260 Wilson Blvd., Arlington, Va.
Arthur Dick, 719 Princeton Pl., N. W.
Samuel Diener, 2808 Ordway St., N. W.
Harold Downey, 1740 M Street, N. W.
George R. Farrell, 1816 R Street, N. W.
Irvin Feldman, 5422 Nevada Ave., N. W.
Max Feldman, 2815 Hillcrest Drive, S. E.
Charles E. Fierst, 4210 Mathewson Drive, N. W.
John F. Finnegan, 1342 E. Capitol St.
Theodore C. Fong, St. Elizabeths Hospital
Eugene A. Forcione, 9111 Alton Parkway, Silver Spring, Md.
Elmer W. Fugitt, 2109 K St., N. W.
Perry W. Gard, (No permanent address as yet)
Mervin W. Glover, 3260 Wilson Blvd., Arlington, Va.
Alfred Golden, Baptist Memorial Hospital, Memphis, Tenn.
Edward J. Grass, 33 Lafayette St., S. E., Grand Rapids, Mich.
Luther W. Gray, 900—17th St., N. W.
James N. Greear, 1740 M Street, N. W.
Milton M. Greenberg, 2440—16th St., N. W.
Henry A. Grennan, 1150 Connecticut Ave., N. W.
Henry B. Gwynn, 1514—30th St., N. W.
Alexander Halperin, 1028 Connecticut Ave., N. W.
J. Phelps Hand, 5424 Nebraska Ave., N. W.
Malcolm D. Harrison, 4535 Yuma St., N. W.
Clarence R. Hartman, 2111 Bancroft Pl., N. W.
Stafford W. Hawken, 1150 Connecticut Ave., N. W.
Clayton H. Hixson, 1835 Eye St., N. W.
Herman S. Hoffman, 1801 Eye St., N. W.
Jay L. Hoffman, 713 Arlington Village, Arlington, Va.
Raymond T. Holden, 3111 — 16th St., N. W.
Saul Holtzman, 1726 Eye St., N.W.
William A. Howard, 1517 30th St., N. W.
Donald W. Ingham, 1418 Good Hope Road, S. E.
Bernard L. Jarman, 4929 Tilden St., N. W.
William D. Jarman, 1150 Connecticut Ave., N. W.
John H. Judson, 1124 N. Highland Ave., Arlington, Va.
Howard Katzman, 2500 Minnesota Ave., S. E.
Edward A. Kelly, 1801 Eye St., N. W.
Allan E. King, 1801 Eye St., N. W.
Elmer Klein, 2026 R St., N. W.
Morris Kleinerman, St. Elizabeths Hospital
Don S. Knowlton, 1835 Eye St., N. W.
Harvey F. Kreuzburg, 7852 — 16th St., N. W.
Henry T. Kulesher, 3825 N. Pershing Dr., Arlington, Va.
Benjamin P. Lafsky, 2025 Eye St., N. W.
Zigmond M. Lebensohn, 1712 Rhode Island Ave., N. W.
Sydney Leventhal, 8248 Georgia Ave., Silver Spring, Md.
James M. Loftus, 2941 Upton St., N. W.
John A. Long, 2642 — 39th St., N. W.

Henry M. Lowden, 1603 19th St., N. W.
Daniel F. Lynch, 1149 — 16th St., N. W.
John Hugh Lyons, 1344 — 19th St., N. W.
George V. Martin, 1150 Connecticut Ave., N. W.
Thomas E. Mattingly, 2200 Rhode Island Ave., N. E.
Lee McCarthy, 1835 Eye St., N. W.
Russell McNitt, 1801 Eye St., N. W.
Matthew Mendelsohn, 1835 Eye St., N. W.
William S. Miller, 1707 Columbia Rd., N. W.
John Minor, 2030 R St., N. W.
Reginald H. Mitchell, 7824 Wisconsin Ave., Bethesda, Md.
Henry A Monat, 1016 — 16th St., N. W.
Joseph M. Moore, Vicksburg Clinic, Vicksburg, Miss.
L. Conner Moss, 1705 Rhode Island Ave., N. W.
Arthur J. Mourot, 811 Prince St., Alexandria, Va.
Edward W. Nicklas, 2200 — 19th St., N. W.
Bernard E. Nunez, 1636 — 32nd St., N. W.
Paul O'Donnell, Westchester Apartments
James A. O'Keeffe, 2025 Eye St., N. W.
Harry B. Orleans, 4841 Kansas Ave., N. W.
Albert E. Pagan, 2509 N. Franklin Rd., Arlington, Va.
John H. Peacock, 1746 K St., N. W.
Frank S. Pellegrini, 3409 Alabama Ave., S. E.
William Raffel, 4815 Georgia Ave., N. W.
Clyde P. Reeves, 1028 Connecticut Ave., N. W.
George W. Reeves, 1746 K St., N. W.
John A. Reisinger, 901 — 20th St., N. W.
Alfred H. Richwine, 5522 Western Ave., Chevy Chase, Md.
William S. Ritchie, 6906 Ritchie Rd., S. E.
Walter J. Romejko, 927 — 17th St., N. W.
Charles P. Ryland, 4901 Massachusetts Ave., N. W.
William A. Ryon, 200 Rhode Island Ave., N. E.
Hilbert S. Sabin, 3200 Garfield St., N. W.
W. Warren Sager, 1835 Eye St., N. W.
Isadore L. Sandler, 1835 Eye St., N. W.
John T. Schnebly, 900 — 17th St., N. W.
Leon Seley, 3221 Livingston St., N. W.
Maurice A. Selinger, 1150 Connecticut Ave., N. W.
Hyman D. Shapiro, 2025 R St., N. W.
Isidore Shulman, 608 Rock Creek Church Rd.
Morris Silverman, 2709 Queens Chapel Rd., Mt. Rainier, Md.
G. Victor Simpson, 1712 Rhode Island Ave., N. W.
Robert L. Simpson, 4000 Argyle Terrace, N. W.
Luther H. Snyder, 1835 Eye St., N. W.
Daniel Sondheimer, 1801 Eye St., N. W.
William G. Sorrell, 616 F St., S. W.
Philip A. E. Stebbing, 800 N. Carolina Ave., S. E.
Walter Stokes, 1835 Eye St., N. W.
S. Jack Sugar, Children's Hospital, Iowa City, Iowa
James M. Suter, Smyth-Washington-Bristol Health District, Abingdon, Va.
Daniel F. Suttenfield, R. F. D. 1, McLean, Va.
John A. Swartwout, 4817 — 14th St., N. W.
S. Ross Taggart, 5327 2nd St., N. W.
J. Lawn Thompson, Jr., 1714 N St., N. W.
Francis D. Threadgill, 2002 R St., N. W.
William J. Tobin, 1835 Eye St., N. W.
George Tolstoi, Uniontown Hospital Association, Uniontown, Pa.
John W. Trenis, 1150 Connecticut Ave., N. W.
Maurice van Kinsbergen, 29 Grant Circle, N. W.
Philip H. Varner, 7202 Connecticut Ave., Chevy Chase, Md.
Joseph J. Wallace, 900 — 17th St., N.W.
Harry S. Weitzman, 1801 Eye St., N. W.
Eugene L. Willard, 5724 — 9th St., N., Arlington, Va.
T. Frasier Williams, 1124 N. Highland St., Arlington, Va.
Paul Wilner, Shoreham Hotel

STUDY OF CHILD HEALTH SERVICES

Responsibility for the local Study of Child Health Services has been assumed by the Section on Pediatrics of the Medical Society of the District of Columbia. This Study is being conducted in conjunction with a nationwide survey under the sponsorship of the American Academy of Pediatrics. Its purpose is to determine and to evaluate the quality of services which are available for the treatment of children.

The proposed Study of Child Health Services has been endorsed by the Executive Board of the District Medical Society. The purpose and scope of the survey have been presented to the members of the Society by Dr. John P. Hubbard, National Director of the Study.

Dr. Edgar P. Copeland, State Chairman of the Academy of Pediatrics for the District of Columbia, is directing the administration and conduct of the local Study. Executive offices have been established at Children's Hospital and distribution of questionnaires will begin at an early date.

The ultimate success of this important undertaking depends upon the coöperation of individual physicians. All practicing physicians in the District of Columbia will be asked shortly to do their part in this Study by giving conscientiously their share of pertinent information. Each physician will be given the opportunity of answering two fundamental questions, on the basis of his personal medical experience and his knowledge of the status of child health facilities in the community in which he practices.

1. To what degree do you, as a physician, carry the load of the medical care of young patients in your community?

2. Have the health facilities in your community met your medical requirements in carrying out the medical care you wish to give your young patients?

Inquiries concerning the conduct and progress of the Study will be welcomed at the executive offices.

NEW TELEPHONE DIRECTORY

The Summer-Fall Directory of The Chesapeake and Potomac Telephone Company will go to the printers on May 29. Physicians who have had changes of address or telephone number since the last directory, or those who wish to make listing changes in the new directory, should consult with the business office of the telephone company before that date. The method of doing so is to call Metropolitan 9900 and ask for the exchange business office of the number in question.

The MEDICAL BUREAU will not be able to list subscribers in the new directory after May 28. Those physicians who have been postponing subscription to the BUREAU are urged to take immediate action. By doing so the subscription will begin at the approximate time of directory publication, a situation which occurs only twice a year. Thus complete coverage is possible from the very beginning. Also, those who subscribe in time for the new directory will be able to take full advantage of BUREAU service during the summer months, a time when most physicians need greater coverage than usual.

Present MEDICAL BUREAU subscribers who wish a change from the present style of listing in the telephone directory are asked to call the BUREAU as soon as possible before the deadline of May 28.

Physicians who were members of the Society at the time of entrance into the armed forces are again reminded of the action taken by the Medical Bureau Committee. The Alternate Listing Service of the MEDICAL BUREAU is being extended to returning Society members without charge for a period of six months.

MEMBERSHIP

The following applicants for Active membership were duly elected to membership at the meeting of the Executive Board, April 22, 1946, in accord with Amendment XI, Section 2, of the Constitution and By-laws of the Society:

Margaret E. Callan, 960 Randolph Street, N.W.
William N. Heffner, 1112—16th Street, N.W.
Clayton H. Hixson, 1835 Eye Street. N.W.
Joel B. Hoberman, 4700 North 20th Road, Arlington, Va.
John W. Nesbitt, 2524—41st Street, N.W.
Thomas J. Pekin, 4619—43rd Place. N.W.
John Bruce Ross, 117 Kennedy Drive, Chevy Chase, Md.
Joseph John Tamasi, 603 McNeill Road. Silver Spring, Md.
Andrew John Welebir, 1726 Eye Street, N.W.

The following applicants for membership will be voted on at the meeting of the Executive Board, June 24, 1946:

For Active Membership

Norman Q. Brill, New York University—1934
John Richard Cain, Medical College of Virginia—1919
Paul Chodoff, Jefferson Medical College—1938
Stewart Clapp, George Washington University—1937
Philip Archelaus Cox, George Washington University—1941
Jacob Mayr Danish, George Washington University—1940
William Sheldon Derrick, George Washington University—1942
Paul Elsberg, Hessische Ludwigs-Universitat Medizinische Fakultat, Giessen, Germany—1932
Edward E. Ferguson, George Washington University—1933
William Travis Gibb, Jr., Cornell University—1927
Thomas Joseph Kelly, George Washington University—1928
William Stanley McCune, Harvard Medical School—1935
G. Foard McGinnes, University of Virginia—1925
George Illarion Mishtowt, Georgetown University—1942
William Russell Wallace Moses, George Washington University—1939
Thomas William Murphy, Georgetown University—1939
Dee Rich Parkinson, George Washington University—1943
Carl John Potthoff, University of Minnesota—1933
Robert Stolar, Georgetown University—1935
John William Walsh, Long Island College of Medicine—1939
Allen Widome, George Washington University—1938
Vincent Thomas Young, McGill University—1937
Anthony Zappala, George Washington University—1942

For Associate Membership

Alvin B. C. Knudson, University of Minnesota—1939
Jasper Wayne McFarland, College of Medical Evangelists—1939
Alfred Monroe Palmer, Georgetown University—1932
Richard Betts Phillips, University of Edinburgh—1932
Alfred H. Richwine, George Washington University—1933

News and Personals

Preliminary arrangements are now being made for two special plane flights to California to accommodate those physicians who desire to attend the **American Medical Association Convention** in San Francisco, July 1–6, 1946. The first plane will leave Washington, Wednesday, June 26, and is intended particularly for those who wish to arrive ahead of the Convention in order to attend the preliminary meetings for cardiologists, pathologists and allergists. The second plane will leave on Sunday, June 30. Both will be day flights, scheduled to leave early in the morning and to arrive in San Francisco late the same evening.

Those who are interested in joining these parties should communicate with Dr. Oscar B. Hunter, 1835 Eye Street, N.W., Republic 4600, or with Theodore Wiprud, the Society's Secretary, at 1718 M Street, N.W., District 3111. Final arrangements have not been made but full details will be published later.

At its meeting, March 25, the **Executive Board** endorsed the Study of Child Health Services which is being undertaken by the American Academy of Pediatrics in the District of Columbia under the leadership of Dr. Edgar P. Copeland, State Chairman, and Dr. William S. Anderson, Secretary of the Executive Committee.

At the same meeting, Dr. Henry C. Macatee was named to succeed himself as Delegate to the Council of Social Agencies for the year beginning April 1, and Dr. Thomas F. Collins was named second Delegate to succeed Dr. William P. Herbst, Jr.

Theodore Wiprud offered his resignation as a member of the Commissioners' Traffic Advisers. The Board expressed its appreciation for his services.

The Committee on Public Policy reported to the Board that it had highly commended Dr. Frederick C. Fishback for his services during the hearings of the House District Committee on the anti-vivisection bill, February 28 and March 1. Dr. Fishback represented the Society at the hearings and scheduled the speakers who testified before the Committee.

Calendar of Meetings

April 1	Subcommittee of Committee on Service Physicians
April 4	Section on Neurology and Psychiatry
April 10	Scientific Meeting of Society Committee on Medical Care
April 12	Board of Censors
April 15	Medical Bureau Committee
April 16	Grievance Committee
April 17	Scientific Meeting of Society
April 18	Service Physicians
April 22	Executive Board
April 24	Special Business Meeting of Society Section on Pathology and Laboratory Medicine
April 26	Interprofessional Conference Subcommittee on Maternal Welfare
April 29	Subcommittee of Committee on Medical Care

The Section on Neurology and Psychiatry met in the Society's library, April 4. Two papers were presented: "Psychiatric Observations on American Prisoners Recovered from the Japanese," Dr. Norman Q. Brill; "Group Psychotherapy at an Army Rehabilitation Center," Dr. Joseph Abrahams.

The Interprofessional Conference held a meeting, March 29, in the Society's building, at which time the new nursing bill was discussed. At the meeting, April 26, consideration was given to adopting a Constitution and By-laws for the Conference. Serving as officers are:

Dr. John A. Reed (Medical Society of D. C.), *Chairman;* Dr. Karl Wood (D. C. Dental Society), *Vice Chairman;* Miss Edith M. Beattie (Graduate Nurses' Association), *Secretary.*

At a meeting of physician-veterans, March 25, in the Medical Society's building, a new organization was founded, to be known as the **District of Columbia Physician-Veterans of World War II.** Officers elected at the meeting were:

Dr. W. Warren Sager, *President;* Dr. Aloysius J. Connolly, *Vice President;* Dr. Stafford W. Hawken, *Secretary-Treasurer;*

Drs. John H. Lyons, J. Lawn Thompson, Jr., Robert J. Coffey and James N. Greear, Jr., *members of the Executive Committee.*

Dr. Norman H. Topping, Senior Surgeon, U. S. Public Health Service, spoke on "Rocky Mountain Spotted Fever" before members and guests of the **George Washington University Medical Society,** April 20. His paper was discussed by Drs. James G. Cumming, Joseph S. Wall, Ralph G. Beachley and V. L. Ellicott, the latter two being Health Officers for Arlington County, Virginia, and Montgomery County, Maryland, respectively.

Two papers were presented before the **Washington Medical and Surgical Society,** March 25, at the Hotel Statler: "Modern Trends in Anesthesia" by Dr. J. Phelps Hand and "Acute Drug Poisoning" by Dr. Robert H. Harmon. The papers were discussed by Drs. Francis J. O'Bryan, John E. Everett, Edward B. Macon, and Dean Paul Briggs of the School of Pharmacy of George Washington University. Dr. George H. McLain, President of the Society, presided.

The Ninth Annual Meeting of the Medical Society of Saint Elizabeths Hospital was held at the Hospital, April 26 and 27, in Hitchcock Hall. Among those who presented papers were Drs. Addison M. Duval, Watson W. Eldridge, Theodore C. C. Fong, Walter Freeman, Ben Karpman, Solomon Katzenelbogen, Z. M. Lebensohn, Albert E. Marland, Anna Coyne-Todd, Harriet E. Twombly, James W. Watts and George D. Weickhardt.

Dr. Winfred Overholser was host at a buffet supper, April 26. He also presided at the meetings. On Saturday evening, April 27, the annual banquet of the Society was held in the Chinese Room of the Mayflower Hotel.

The office of **Procurement and Assignment Service for Physicians in the District of Columbia,** which had been housed in the offices of the Medical Society of the District of Columbia at 1718 M Street, N.W., since July, 1942, was terminated officially on March 31, 1946.

The Selective Service System was placed in operation on October 16, 1940. A year later, October 30, 1941, the Procurement and Assignment Service for Physicians, Dentists and Veterinarians under the War Manpower Commission was established, but it was not prepared to function until early in 1942. On May 12, 1942, 1,218 physicians registered with the Service in the District of Columbia.

Dr. F. X. McGovern served as State Chairman of the Committee on Procurement and Assignment for the District of Columbia until he resigned at the end of 1942. He was succeeded January 1, 1943, by Dr. Paul F. Dickens. Dr. McGovern continued as a member of the Committee after he resigned as Chairman. Mr. Theodore Wiprud served the entire time as Secretary of the Committee. Others on the Committee with Dr. McGovern and later, Dr. Dickens were Colonel A. Clagett Gray, State Medical Officer of District Selective Service, Drs. James A. Gannon, Casimir Leibell, James A. Lyon, Henry C. Macatee, A. Magruder MacDonald, Henry R. Schreiber and Charles Stanley White. Dr. W. C. Goines represented the Medico-Chirurgical Society, Inc. on the Committee. Two physicians who served until their death were Drs. William T. Davis and Luther H. Reichelderfer.

"Know Your Public Health Nurse Week," April 7–13, brought a tribute to the public health nurses of America from President Truman.

During April, the **National Cancer Control Month,** the District Health Department held special cancer diagnostic clinics in coöperation with seven local hospitals, i.e., Gallinger Municipal, Georgetown, Providence, George Washington University, Garfield Memorial, Mount Alto and Freedmen's.

National Child Health Day was celebrated on May 1. On May 12 special programs were held in hospitals all over the Nation in observance of **National Hospital Day.**

Walter Reed Hospital took occasion on Army Day, April 6, to hold open house in order to display latest medical procedures in plastic surgery, and developments in building and fitting artificial limbs.

In December 1945 the **Maryland and District of Columbia Association to Control Epilepsy** was chartered as a non-profit corporation organized exclusively to advance the cause of controlling epilepsy. Washington physicians included on the Board of Trustees of the new organization are Drs. Joseph W. Stein and John A. Washington, both

Active members of the District Medical Society. Members of the Medical Society who have been selected to serve on the Advisory Board of the Association are Drs. William Earl Clark, Roger Cohen, Edgar P. Copeland, Elmer Klein, Z. M. Lebensohn and Joseph S. Wall.

The Instructive Visiting Nurse Society held a luncheon meeting, April 9, at the Roger Smith Hotel, with approximately 120 members and guests present. Dr. Howard A. Rusk, on the staff of the *New York Times*, was the principal speaker. Dr. Rusk, formerly a Colonel in the U. S. Army and chief of the convalescent division of the Air Forces, urged a broad program of rehabilitation for veterans and civilians in what he called "the third phase of medical care."

The occasion marked the completion of 25 years of service by Miss Gertrude H. Bowling, Executive Director of IVNS. In appreciation of her services Miss Bowling was presented with a silver box and a sum of money.

Among those seated at the speaker's table were Dr. William Earl Clark, President of the Medical Society of the District of Columbia; Dr. Herbert P. Ramsey, Chairman of the Washington Metropolitan Health Council; Dr. George C. Ruhland, District Health Officer; Dr. C. E. A. Winslow, Professor Emeritus of Public Health at Yale Medical School, who is in Washington to take charge of the current health and hospital survey of the Washington Metropolitan Health Council; Mrs. W. A. Roberts, Executive Secretary of the Council of Social Agencies; Miss Ashby Taylor and Miss Edith M. Beattie, President and Executive Secretary, respectively, of the Graduate Nurses' Association. Miss Elsa Peterson, President of the Board of Directors of IVNS, presided.

Dr. William A. Morgan attended the dedication ceremonies, April 19, of a 200-bed hospital in Ciudad Trujillo, capital of the Dominican Republic, which was named for him. The new hospital has been dedicated to Dr. Morgan in appreciation of his medical services to the Dominican people.

Dr. Morgan first visited the country ten years ago with Joseph E. Davies, former Ambassador to Moscow. On successive visits to this country, Dr. Morgan, who specializes in otolaryngology, worked in behalf of the poor and sick of the island. He has been assured that the new William A. Morgan Hospital will concentrate on providing care for the underprivileged.

Mrs. Morgan and several friends accompanied Dr. Morgan on the trip, which was made by plane. Among them was Dr. W. T. Sanger, President of the Medical College of Virginia, Richmond, where Dr. Morgan received his medical education. Dr. Sanger expected to arrange for an annual transfer of personnel between his school and the new Dominican institution, with several members of the Virginia faculty spending some time in Trujillo City each year while Dominican students are interning in Richmond.

Dr. Winfred Overholser, Superintendent of St. Elizabeths Hospital, participated in a Symposium on Present-day Social and Economic Aspects of National Health during the annual meeting of the American Philosophical Society in Philadelphia, April 18. Dr. Overholser spoke on "Mental Hygiene."

Major General Warren F. Draper, Deputy Surgeon General, U. S. Public Health Service, was present at the same meeting. He spoke on "Public Health Experiences in the European Theater of Operations."

Dr. Walter Freeman left April 7 via Transcontinental Clipper for London, England, where he was invited to lecture on "Psychosurgery" by the Section on Neurology and Psychiatry of the Royal Society of Medicine. He returned April 24 on the *Ile de France.*

The first annual meeting of the **Maryland-District of Columbia Chapter of the American College of Chest Physicians** was held at the Belvedere Hotel, Baltimore, on April 22, in joint session with the **Medical and Chirurgical Faculty of Maryland.** Major General S. U. Marietta of Washington presided at the scientific session. Dr. Edgar W. Davis, Professor of Thoracic Surgery at Georgetown University School of Medicine, and Dr. Brian B. Blades, Professor of Surgery, George Washington University School of Medicine, presented papers on "Surgical Management of Patent Ductus Arteriosus" and "Unusual Thoracic Surgery Cases," respectively. Dr. Herman E. Hilleboe, Chief of the Tuberculosis Control Division of the U. S. Public Health Service, also appeared on the program as a discussant.

Dr. J. Winthrop Peabody, Past President of the American College of Chest Physicians, was the guest speaker at the banquet. His subject was "Our College and College Chapter."

Dr. Courtney M. Smith has been appointed new Medical Director for the **American Red Cross,** succeeding Dr. G. Foard McGinnes, who was recently made Vice Chairman for Health Services. Dr. Smith, a veteran of World War I, has served with the organization since 1944 as Deputy Medical Director and Director of Disaster Medical Service. He is a graduate of the University of Oregon School of Medicine and Yale University, where he obtained the degree of doctor of public health. In May 1945 he was given leave from the Red Cross to represent the U. S. Public Health Service with the Army's Strategic Bombing Survey and did a four months' tour of duty in Germany.

Friends of the late Dr. James Lloyd Collins have established a Memorial Research Fund in the field of surgery which will honor his name and be known as **The James Lloyd Collins Research Fund.** It is desired that the Fund shall remain intact and that the interest derived therefrom shall be used to carry on special research projects in the field of surgery at the George Washington University School of Medicine. All checks should be made payable to George Washington University, marked for the James Lloyd Collins Research Fund, and mailed to the School of Medicine, 1335 H Street, N.W.

Dr. William P. Herbst gave a talk on "The Present Status of the Management of Carcinoma of the Prostate" at the Mid-Atlantic Section of the American Urological Association in Atlantic City, N. J., March 19.

Dr. J. Winthrop Peabody was guest speaker at a joint meeting of the Laennec Society of Philadelphia and the Pennsylvania Chapter of the American College of Chest Physicians. The meeting was held April 3 at the Bellevue Stratford Hotel, Philadelphia; his subject, "Laennec the Physician."

Dr. Peabody has been appointed Associate Editor of the *Journal of Diseases of the Chest.*

Dr. John W. Cronin, Senior Surgeon, U. S. Public Health Service, addressed the 1948 class of the School of Nursing of Garfield Memorial Hospital. The capping exercises were held at Wilson Teachers College, March 22.

Dr. Daniel L. Seckinger, Assistant District Health Officer, participated in a broadcast, March 19, over WRC, with Colonel Donald G. White, District Army Engineer for the Potomac, Rappahannock and Patuxent watersheds. The talks described the Japanese water chestnut which infests the lower Potomac River and the steps which should be taken to eradicate this potential malaria menace to Washington and vicinity.

Dr. Wallace M. Yater was invited to address the members of the Medical and Chirurgical Faculty of the State of Maryland at their 148th annual meeting, April 23 and 24, in Baltimore. His paper was entitled, "Coronary Artery Disease in Young Men—a Study of Four Hundred Cases Proved at Necropsy." Following that meeting he gave a similar address to the officers of the Regional Hospital at Fort Meade, Md.

Dr. Albert E. Pagan has been named Chairman of the Home Service Committee of the Arlington Red Cross Chapter. Dr. Pagan returned to Washington recently after having served more than five years in the Navy. He held the rank of Captain.

Dr. W. LeRoy Dunn addressed a group in the Arlington Health Department, March 27, which was called together to develop plans for sponsoring a mass chest X-ray for combatting tuberculosis in the County. The survey was completed during April.

Lt. Colonel Charles E. Fierst has been awarded the Bronze Star Medal for "meritorious service in connection with military operations, as Chief of the Anesthesia Section, Officer in Charge of Operating Pavillions and Officer in Charge of Oxygen Therapy, 99th United States General Hospital, from 5 June 1944 to 8 May 1945." On three occasions during the period of service for which he was cited, as a member of surgical teams, Colonel Fierst "demonstrated outstanding ability to carry on under trying and hazardous conditions," the accompanying citation stated. His "initiative, energy and keen sense of responsibility contributed materially to the prompt care of the wounded and to the alleviation of their suffering, and his work has been in accordance with the highest medical and military standards," the citation concluded.

Dr. Edgar P. Copeland, State Chairman for the District of Columbia of the American Academy of Pediatrics, presented the need, purpose and scope of the Study of Child Health Services now in progress before the District Dental Society, April 9.

Dr. John W. Lawlah, Dean of Howard University School of Medicine, and Professor of Radiology at Howard University, has resigned his position as Dean, effective July 1, in order to devote his entire time to his work in radiology. Dr. Lawlah has been Dean of the Medical School since July 1941.

Dr. Sidney Berman has been appointed Director of the Washington Institute of Mental Hygiene, replacing **Dr. Rex E. Buxton,** who resigned to enter private practice. Dr. Winfred Overholser, Chairman of the Board of Managers, made this announcement at the Institute's annual meeting, March 29.

Dr. Walter Stokes and Dr. Leopold E. Wexberg participated as speakers in a series of lectures sponsored by the Y. W. C. A. during March for employed girls in Washington. Dr. Stokes also addressed a group of men and women on marriage problems during a series of lectures sponsored by the Central Branch of the Y. M. C. A.

Dr. Winchell M. Craig of the Mayo Clinic, Rochester, Minn., well known to many Washington physicians, was elected President of the Society of Neurological Surgeons at the annual meeting of the organization, which was held in Nashville, Tenn., April 10. Dr. Craig served as chief of the department of surgery at the Naval Hospital at Bethesda, Md., from July 1942 to November 1945. Last November he was promoted to Rear Admiral, the first medical officer in the Naval Reserve to achieve that grade. At that time he was placed in charge of the training division of the Bureau of Medicine and Surgery. He left the service to return to the Mayo Clinic, January 31.

Dr. Leonard M. Dub gave a talk on "Understanding Children" before the nursery school teachers of the University of Maryland, March 26.

Dr. Clarence K. Fraser was recently appointed by the District Board of Public Welfare to serve on a committee which will study the revision of adoption and placement laws. Dr. Fraser is Chairman of the Medical Society's Subcommittee on Maternal Welfare.

Drs. Roy G. Klepser and H. A. Latane participated in the Metropolitan Washington Tuberculosis Conference held at Howard University School of Medicine, April 25. **Dr. Daniel Leo Finucane,** President of the Conference, presided at the morning session.

Michael M. Davis, a member of the Executive Committee of the newly organized Committee for the Nation's Health and long a proponent of compulsory health insurance, appeared on a radio program over WINX, April 9, with **Theodore Wiprud,** Secretary of the District Medical Society. Merits pro and con of the Wagner-Murray-Dingell bill were presented.

Mr. Wiprud addressed members of the Kober Medical Society, April 15, at the Mayflower Hotel on the subject of pending health legislation.

BOOKS RECEIVED FOR REVIEW

Acknowledgment is made of the following books which have been received for review:

Illness and Medical Care among 2,500,000 Persons in 83 Cities, with Special Reference to Socio-economic Factors (A Collection of 27 Reprints). Federal Security Agency, United States Public Health Service. Washington, D. C.: Government Printing Office, 1945.

Synopsis of Physiology. Rolland J. Main, Ph.D., Professor of Physiology, Medical College of Virginia, Richmond. Pp. 341, illustrated. St. Louis: Mosby, 1946.

The Wheel of Health. G. T. WRENCH, M.D. (Lond.) Pp. 147. Price, $1.50. London: C. W. Daniel Co., Ltd., 1938. Reprinted, 1945, by Lee Foundation for Nutritional Research, Milwaukee, Wis.

BOOK REVIEW

Man Against Pain. The Epic of Anesthesia. HOWARD RILEY RAPER. Price, $3.50. Pp. 337. New York: Prentice-Hall, 1945.

Dr. Raper's book does not become really interesting until Part II. Perhaps this is because there is nothing particularly striking about man's battle against pain before the 1840's. At any rate, the next two parts of the book are full of interest and very well handled. They make up for any misgivings the reader may have had wading through Part I. The fascination latent in the story of anesthesia is enhanced by the author's great enthusiasm for the entire subject and by his carefully supported devotion to Horace Wells as the true discoverer.

It is interesting to learn something of the story of "those who came close" to making the great discovery—three Englishmen, Davy, Hickman, and Collier; a country doctor in Georgia, Dr. Crawford W. Long (who used ether in surgery as early as 1842, but is denied credit for the discovery by Dr. Raper because he did not spread the news or recognize and develop its usefulness); and a Bostonian, Smilie.

Dr. Horace Wells, a Hartford, Conn. dentist, attended an entertainment in his home town on the evening of December 10, 1844. It was " 'A Grand Exhibition of the effects produced by inhaling Nitrous Oxide, Exhilarating or Laughing Gas.' " Wells was struck by the fact that one of the subjects knocked his shins so badly while under influence of the gas that they were lacerated and bleeding, yet he did not realize he had injured himself. This is supposed to be the episode which started Wells experimenting on himself and others, and developing to his full satisfaction the use of nitrous oxide gas as as an anesthetic in dentistry. How to convince others successfully was not a piece of luck bestowed by the Fates upon Wells, and from this fact stemmed the tragedy of his ensuing days.

It took Dr. William T. G. Morton, another dentist and a former student of Wells, to gain the luck of giving a demonstration on October 16, 1846, which shook the world into grasping the full significance and value of Wells' discovery. Although Morton did use some ether mixed with nitrous oxide, what he did was not sufficiently different from Wells' experiment for credit not to have been given where it was due—by Morton to Wells. The tragedy of Morton's life lay in his unwillingness to share honors for the great discovery. The Fates hold back a great deal—in the case of the discovery of anesthesia they were careful not to mete out all to any one man.

What a tragedy that the handful of men who were granted great parts in the discovery of anesthesia could not have risen to the heights of their discovery instead of falling into the dejection and despair awaiting all self-seeking mortals.

This discovery, one of man's greatest victories of all time, has made possible so much progress in medical and surgical science. Dr. Raper gives a brief account of the development of anesthesia from the days of Wells and Morton through World War II with particular emphasis on the discovery of cocaine in 1884 by Dr. Carl Koller, the discovery of the barbiturates and intravenous anesthesia by Dr. Emil Fischer about 1903, and the use of new gases in anesthesia such as ethylene, cyclopropane, vinethene and propethylene. The reader would like to know much more about "Modern Anesthesia," but to the credit of Dr. Raper and his book let it not be lost sight of that his main interest is in telling the Wells-Morton story. This is what he does best; what goes before and what come after are merely a bird's-eye-view background and foreground for the main drama.

M. B Y.

WILLIAM ISAAC ROBEY, M.D.

(1873–1945)

The Society's office has just been notified of the death of Dr. William I. Robey, on October 5, 1945, at Georgetown Hospital. He had been in ill health for a number of years.

Dr. Robey was born in Herndon, Virginia, June 25, 1873. He graduated from Columbian University (now George Washington University) School of Medicine in 1902. Prior to 1924, when he began practicing in the District of Columbia, he practiced in Herndon and Alexandria, Virginia.

Dr. Robey was elected to Active membership in the Medical Society of the District of Columbia in 1925. He was also a member of the American Medical Association.

For several years before his death, Dr. Robey resided in Herndon, Va. He is survived by a daughter, Mrs. Margaret Milliken, of Herndon.

James Lloyd Collins, A.B., M.D., F.A.C.S.

JAMES LLOYD COLLINS, A.B., M.D., F.A.C.S.

(1902–1946)

Dr. James Lloyd Collins, who died unexpectedly at Doctors Hospital on March 23, at the age of 44, was known and loved by an unusually large number of friends in Washington and throughout the Middle West. On colleague and friend alike he left the impression of a vivid personality. His disarming and almost ingenuous manner endeared him to all who knew him and letters have poured in from all classes of people, which convey the heartbreak of friends who truly loved him.

Dr. Collins possessed a high professional conscience and a marked understanding and sympathy for his patients; he spared neither time nor effort in their behalf. His loyalty to his colleagues and his deep interest in the welfare of the hospitals which he served were salient characteristics of a pleasing personality.

The accompanying portrait may recall to hundreds of colleagues, students and friends the lovable social graces and pleasantries of Lloyd Collins, and his accomplishments in the field of surgery, but neither the portrait nor this printed word can in any way portray the real character and influence of such a man.

We cannot separate his life in Washington from his early life in Kansas, for it was there that he developed his love for the medical profession and particularly for surgery. He was born March 19, 1902 at Oxford, Kansas, the son of the late Dr. Melvin Collins, who served a large rural community, and as a young boy Lloyd learned firsthand something of the rugged life of a country doctor. In the wee hours of a cold winter's night he would accompany his father to some rural section and hold an oil lamp or help administer an anesthetic while his father delivered a baby. It was during those formative years that the foundation was laid upon which later was built the lovable character and trustworthy surgeon whom we honor.

He qualified at the University of Kansas Medical School in 1928, having previously earned his A.B. degree in the same institution. He served a two-year internship in the Bell Memorial Hospital, the hospital of his alma mater, and later served a two-year fellowship in the Surgical Department of the Crile Clinic at Cleveland, Ohio. He later received an appointment as chief resident in surgery at the Gallinger Municipal Hospital, Washington, D. C., and while at this institution there developed the friendship between him and the writer which culminated in an associate partnership beginning July 1, 1934 and continuing until his death.

He married Verle Williams of Kansas City, Kansas in 1927, and one son, James Lloyd, Jr., was born November 1, 1931. Mrs. Collins died in Washington in February, 1943. He married Margaret Mary Boyle of Washington, D.C., January 10, 1946, who survives him together with his son, now 14 years old, and one sister, Mrs. Harriet Barnes of Camargo, Oklahoma.

Dr. Collins was an Active member of the Medical Society of the District of Columbia; a member of the Hippocrates-Galen Society, the Washington Academy of Surgery, and the George Washington University Medical Society; a Fellow of the American Medical Association and the American College of Surgeons; and a Diplomate of the American Board of Surgery. He was an Associate in Surgery at the George Washington University School of Medicine, and a member of the Executive and Teaching Staff of Doctors Hospital.

In the early days of World War II, Dr. Collins was rejected for military service because of a slight physical handicap, and he set himself to the task of caring for civilians. The increased work that fell to Washington physicians during the war years was undoubtedly a large factor in his untimely death. He refused to spare himself, was constantly on duty, and never complained of being tired. One colleague writes: "Lloyd Collins was temperate in all things, except work."

Two aspects of his character which always impressed those who knew him were his absolute sincerity and his devotion to his fellow men. He was no respecter of any artificial division of society, but gave himself unstintingly to all alike. In his passing we have lost a friend who cannot be replaced, and a surgeon whose honesty and skillful efforts can never be surpassed.

"His life was gentle; and the elements
So mix'd in him, that Nature might stand up
And say to all the world, 'This was a man!' "

Charles Stanley White, M.D.

Suppurative Diseases of Lungs and Pleura—Hirsh

(*Continued from page 213*)

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Uterine Atony—Dill and Murphy

(*Continued from page 216*)

able at least 2 bottles of plasma and 2 pints of Rh negative, type O (universal donor) blood, with sterile equipment for the use of this material. In most cities arrangements could also be made to provide exchanges with other hospitals and/or blood banks by which large amounts of blood could be made available within a reasonable length of time, for in cases similar to the one reported a small amount of blood or plasma would not be life-saving but would only be life-sustaining until ample replacements were available.

CONCLUSIONS

Blood and plasma are invaluable adjuncts to the obstetrical profession even though excellent methods of third stage management and purified oxytocics are generally utilized.

An emergency setup of blood and plasma with suitable equipment for administration gives one the same feeling of confidence for the future as a well appointed insurance policy.

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Footnotes—Observer

(*Continued from page 230*)

such radio facilities in connection with the Society's telephone exchange. . . . Your Observer was hastily scanning the morning newspaper a few days ago when he came across the headline, "Wagner Bill of Ormandy Applauded." It did not dawn on him until he began reading the article that it had nothing to do with the widely discussed health legislation but referred to the all-Wagnerian program offered by the Philadelphia Symphony Orchestra the night before.

T. W.

MEDICAL ANNALS

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INTRAVENOUS FLUIDS WITH PARTICULAR REFERENCE TO AMINO ACIDS*

CHARLES S. WHITE, M.D., Sc.D., F.A.C.S.
Washington

IT HAS been said, possibly with a little deviation from the truth, that all we inherited from World War I were taxes, the flu, and the Thomas splint. The legacy of World War II has not been fully appraised, but we know that it has opened new avenues of scientific investigation that were impossible to pursue with the world at peace. Many fields in the sphere of medicine were invaded, and an approach to standardization of some surgical practices was made possible, a definite scientific advance.

This in no manner or means compensates for the shocking casualties, but reminds us that something was salvaged out of the frightful global struggle. The use of blood and blood plasma stands out conspicuously on the credit side of war.

One thing seems definitely settled: There is no substitute for properly matched blood in the treatment of hemorrhage (see fig. 1); and as hemorrhage and shock are frequently associated, blood is the remedy par excellence in shock with hemorrhage. In the early years of the war it was not possible to furnish blood in the combat areas, but the perseverance of the Transfusion Service overcame all obstacles, and before the termination of hostilities liquid type O blood was

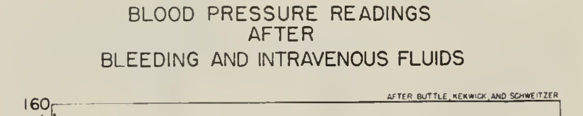

Fig. 1. Comparative effects on blood pressure of citrated blood, plasma serum and saline, after bleeding in animals (after Buttle, Kekwick and Schweitzer).

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* Read before the Society, April 17, 1946.

used five days or less after it was withdrawn from the donor in this country. It was kept liquid by refrigeration and was packed in containers that could be dropped from planes with negligible breakage. From reliable sources we learn that over 600,000 units of type O blood were given, with only 3 per cent reactions. This contribution to the subject of blood transfusion should be applied to civilian practice by donor centers in every municipality, with provision for prompt delivery upon demand.

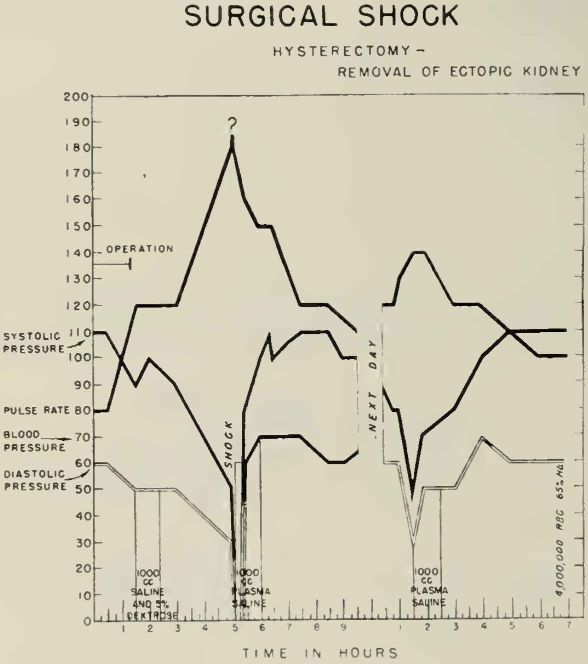

FIG. 2. Clinical effects of saline and plasma in shock

Plasma occupies a unique place in the treatment of emergencies (fig. 2). Strictly speaking, plasma is not a substitute for blood; it is not just as good, but, to use an expression common to the stage and screen, it is an understudy or stand-in for blood. In shock or hemorrhage it should be given if whole blood is not available. It can be kept in a liquid state at room temperature for two or three years and can be administered without typing or fear of serious reactions. The only recorded death from plasma transfusion which we have seen reported occurred in a case in which the plasma was not filtered, a very serious omission in the technic. For medical or surgical hypoproteinemia, plasma has proven to be of inestimable value. We were the first to suggest and to administer plasma in the diarrhea and inanition of the premature and newborn, and the practice has been followed by most pediatricians. In the preoperative and postoperative treatment of the poor risk case, it has been a sheet anchor.

The cost of plasma unfortunately restricts its use but does not impair its standing as a therapeutic agent. For use in civilian practice plasma in liquid form is preferable to either the dried or frozen article because of its simplicity in administration and lower cost. Although the dried and frozen plasma may retain some constituents not preserved in the liquid form, the lack of these elements is relatively unimportant in the routine use of plasma. It may be of interest to know that over 13 million units of plasma were processed for use in World War II.

The attention of the profession was called to protein deficiency by Jones and Eaton[1] in 1935 and later by Whipple[2] and his associates many years before their contributions were appropriated by clinicians. In a measure, this was unavoidable, because no protein solution for intravenous use was immediately available. The commercial laboratories sensed the possibilities of such a solution, with the result that several protein solutions for intravenous use are now procurable. All have passed through the animal experimental stage, but it is regrettable that they are not better designated and standardized.

As blood chemistry became a part of the examination of our patients, the protein content of the blood assumed an important role. We can look back, not without chagrin, upon the confidence we placed in the subcutaneous administration of salt solution, then its intravenous use, later glucose and buffer solutions in the treatment of hemorrhage and shock, feeling we had reached the ultimate in supportive therapy. With better knowledge of the part played by proteins in the body economy, it is safe to state we overplayed saline and glucose solutions, somewhat to the disadvantage of the patient.

Proteins are indispensable in our daily metabolism and must be supplied in some way. Most diets contain sufficient for the bodily needs, even though not well balanced. A mere per cent of protein in food is not the answer; there must be protein which can be assimilated, converted, and stored. We measure foods by their biologic values. Quantity for quantity, milk has a higher biologic value than gelatine, although the latter contains about 30 times as much protein as milk. But gelatine protein is not appropriated by the body as tissue proteins.

In the digestion of proteins the gastric juice hydrolyzes the protein molecule and may liberate a small quantity of amino acids in the stomach, but the major digestion consists in the conversion of proteins in the intestines into amino acids which are conveyed by the portal vein to the liver, where it is further subdivided and distributed, some for storage and others for active participation in metabolism. It has been said that the liver is the factory, the agent, and the bank of the proteins.

The plasma of the blood is almost wholly the product of liver metabolism, and the circulatory system is the means by which the proteins are transported to individual cells. Every living animal cell contains a protein, and the human body contains at least 1,600. We have reason to believe that the proteins of the body can be physiologically classified into 3 groups, the fixed, the labile, and the transitional, and their significance is apparent when we state that the labile proteins are largely in the intracellular fluids and are used in normal metabolism; the transitional are found in the muscles and organs, including the liver, and respond to unusual demands; while the fixed, residing in the plasma and liver also, represent the last line of defense when the proteins are demanded, especially in infections and chronic constitutional diseases.

We generally think of loss of weight as reduction in fat, but after a long illness or an operation, it is not adipose tissue alone but carbohydrates and proteins as well. It is not possible to compute the loss of fat, but the chemistry of the blood is often an index of the loss of protein, more serious at times than the loss of lipoids. The proteins of the plasma are easily estimated, and they furnish an index to the body proteins (fig. 3). The normal is estimated at 6.5 to 7.5 Gm. per 100 c.c. of plasma. It rarely exceeds the upper figure, but low protein levels are met in a variety of surgical and medical conditions, under the all-inclusive name of hypoproteinemia.

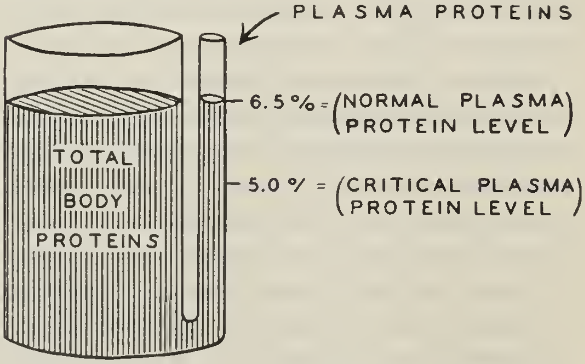
PLASMA PROTEINS
6.5 % = (NORMAL PLASMA PROTEIN LEVEL)
5.0 % = (CRITICAL PLASMA PROTEIN LEVEL)
TOTAL BODY PROTEINS

FIG. 3. Diagrammatic illustration of plasma protein levels

The proteins not only furnish calories and a number of essential chemical elements, but by the virtue of the albumin and globulin molecules regulate osmotic pressure and fluid balance in great measure.

When an individual excretes the same amount of nitrogen that he takes in by any route over a period of several days, he is said to be in nitrogen balance or equilibrium. The usual source of nitrogen is ingested foods, but this can be complemented parenterally, in whole or in part; while the excretion is 90 per cent in the urine, the remaining 10 per cent, which is rather constant, is in the stools. The balance may be upset by persistent diarrhea, draining fistulae, and sinuses.

Negative nitrogen balance operates when the excretion of nitrogen is greater than the intake, and the deficit is made up from the transitional and labile proteins of the body. Should the negative balance persist, it is registered in the plasma proteins as a lower level. A reversal of the albumin-globulin ratio may follow.

A positive nitrogen balance is usually present during active growth or regeneration. More nitrogen is consumed than excreted, and it is believed that the excess is stored or used in body growth. A low intake of protein, just sufficient to maintain nitrogen balance, is not considered ideal, since it affords no reserve or cushion for excessive demands. Since vitamins and minerals are often combined with proteins in the food, we may have a deficit in the vitamins and minerals with just enough protein to satisfy the equilibrium. The well nourished patient can meet an extra demand for protein, as he uses the stored proteins during the emergency, but the continuous demands without a corresponding intake reduce the body proteins as a whole. The plasma normally carries from 6 to 7.5 grams of protein per 100 c.c. and shows little variation in health, but an exhausting illness or severe infection will make inroads on the bodily proteins, which will be reflected in a reduction in the plasma proteins. A critical level is arbitrarily set at 5 grams per 100 c.c. of plasma.

The reduction of 1 gram of protein in the circulating plasma is equivalent to the loss of 30 grams of the body protein, according to Elman.[3]

The amount of nitrogen excreted daily is 8 to 11 grams, or 50 to 69 grams of protein, and food which contains this amount must be provided; otherwise the patient shows the deficit as a negative nitrogen balance. A constant drain upon the body proteins lowers the plasma proteins to a variable degree.

The causes of protein deficiency may be due to (1) faulty metabolism, (2) deficient intake, (3) impaired digestion and absorption, (4) excessive losses, such as vomiting and diarrhea, (5) hypermetabolism, (6) liver dysfunction, (7) other factors singly or combined, such as infections and constitutional diseases.

Plasma protein estimations afford a quick and accurate method of measuring the body proteins; and while such factors as dehydration, hemoconcentration, or blood hydration must be taken into account, this laboratory procedure has been so standardized that it occupies an important place among our laboratory aids. A single determination, like a single blood count, may be of little value, but repeated tests more than pay for the labor involved. We regard levels of 6 grams or less as in the hypoproteinemia range and not to pass unheeded. Levels of 4.5 to 5 are found usually in the very ill patients.

Hypoproteinemia may be classed as medical or surgical, but we are concerned more particularly with the latter. The surgical patient not only may present himself with a low protein level, but he submits to an operation which demands more protein in the reparative processes; at the same time the patient is unable to take and digest food of any description or only food which has a very low protein content.

This state of affairs has received the attention of several observers. Reigen and her associates[4] at the University of Pennsylvania noted that the average weight loss in 304 operative cases was 6.5 pounds in an average hospitalization period of 15.2 days. In 17 abdominal cases the loss was 12.4 pounds. We checked the protein levels of 50 patients on admission to Gallinger Municipal Hospital, and using 6 Gm. per 100 c.c. of plasma as a low normal, we found the protein level below this point in 16.5 per cent of cases of cholecystitis, 33 per cent of cases of carcinoma of the stomach, and 33 per cent in cases of non-bleeding duodenal ulcers.

We embarked on a study of postoperative cases and selected what we considered the minimum risk major case, namely, hernioplasties. In 19 out of 20 cases on routine hospital care and diet, over a period of 9 days, we found an average daily loss (negative nitrogen balance) of 10.68 grams of nitrogen or 613 grams of protein at the end of 9 days (see fig. 4). Many others have made similar observations. Ariel and his associates[5] found that 59 per cent of cases of carcinoma of stomach, 36.5 per cent of cases of carcinoma of the colon, and 33 per cent of cases of benign lesions of the gastrointestinal tract had recognized hypoproteinemia.

Kozoll[6] reported 0.5 per cent decrease in the average total protein in patients after operation, and Castin and his associates[7] state that 0.5 gram or more of protein was lost in 58 per cent of major abdominal operations.

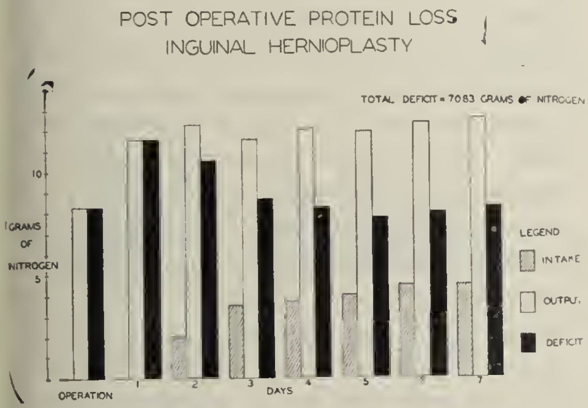

FIG. 4. Protein loss in uncomplicated hernioplasty

Many patients reach the hospital and the operating room with a low protein level. In some instances the disease for which he seeks relief may be the cause, and in others it may have an indirect relation. Regardless of the cause, too many patients submit to major operations before any effort is made to check the proteins or treat the condition if it exists. Postoperatively, and we have in mind major cases, patients receive little or no proteins for 2 to 4 days after operation. The food they receive by mouth is not only small in amount but low in proteins, while the parenteral fluid usually consists of glucose and salt solutions. Many of the surgical cases involving the alimentary tract have the stomach constantly empty by the use of the Wangensteen evacuation, and while it is efficient in this respect, it also depletes the sodium salts. Salt solution and glucose do nothing toward maintaining a nitrogen balance, and the patient may go 3 days or more without protein, and the next few days with an inadequate amount. In the minor case, depriving the patient of proteins for a few days has no untoward consequences, but in the seriously ill patient, it may pave the way for a grave hypoproteinemia.

A low protein level is a plaguing complication in an ill patient. It has been pointed out by Ravdin and others[8] that we may expect edema, both local and general. He was able to demonstrate that hypoproteinemia was associated with edema about gastrointestinal suture lines to such an extent that obstruction may follow. The edema is not confined to areas involved in the operation, but may be present in the heart, lungs and liver, and throughout the body as well. Low protein levels permit an increased interstitial fluid volume. The albumins in the plasma maintain the balance of fluid by the colloid osmotic pressure. Koster and Shapiro[9] were the first to establish the causative relation between low protein levels and wound disruption.

Since large fractions of serum calcium are combined with plasma proteins, reduction in proteins necessarily reduces the blood calcium, and retardation in bone healing may ensue, according to Rhoads and Kasinskas.[10]

Resistance to infection can be traced directly to depleted proteins, and according to Whipple[11] this depletion makes an animal more susceptible than an animal suffering with anemia. Miller, Ross and Whipple[12] have shown that liver dysfunction and susceptibility to toxic substances is increased in hypoproteinemia.

Muscular atrophy and emaciation are byproducts of low protein levels, particularly if the level remains low over a protracted period.

Major General Norman T. Kirk,[13] in discussing the problem of the paraplegic, said, "Perhaps the most important advance in the management of the decubitus ulcers was the discovery of the enormous loss of protein by this route. . . . To obtain a zero balance under these circumstances, let alone a positive one, was no simple matter."

LeFevre, McDonald and Corcoran,[14] in a discussion of protein deficiency, state that "it may be absolute as in famine edema, or relative, and due to increased metabolic demand or loss due to burns or severe eczema. Protein deficiency is accentuated when the diet is low in calories as well as in proteins, because valuable stores of protein must be burned for energy production. The failure of protein anabolism, which characterizes states of damage or disease, predisposes to hypoproteinemia and is only partially reversed by the ingestion of large amounts of protein. One of the recently recognized complications of nutritional hypoproteinemia and edema is the tendency to disruption of wounds, particularly those of the abdominal wall."

Jackson,[15] in a study of Belgian and German children after the last war, found that in those with accentuated lower levels of plasma proteins there was a retardation of 1 to 5 years in height and weight.

Cannon[16] states the evidence points more and more to the conclusion also that many important aspects of the problem of infection and resistance are essentially nutritional.

Co Tui[17] has recently made a contribution to the treatment of peptic ulcers in which he based his treatment on the deficiency of proteins. He supplied proteins parenterally and reported cures in cases resisting other types of treatment.

In chronic hypoproteinemia we may expect infections, low calcium with slow bone healing, liver toxemia and retardation of growth. It is in those cases that cannot ingest sufficient food for one reason or another that parenteral fluids, including proteins, should be administered.

We have been engaged for several years in experimenting with the use of one of the several protein solutions available and have reached that place in our work where it is possible to be specific and present cases in which the measures we recommend have been carried out to a successful conclusion. In the early part of this paper, attention was called to the low protein level of patients on admission and that such patients after operation were proper ones for the administration of the solution.

The solution is a heat sterilized, pyrogen-free, enzymatic digest of mammalian proteins. The end product has a pH of 6.5, contains approximately 5 per cent protein (amino acids and polypeptides), and 0.3 per cent sodium chloride. Every batch was animal-tested before we used it.

The patients who received the solution were those who, in our opinion, needed parenteral protein. Many of them were seriously ill in Gallinger Municipal Hospital. A record of each injection was kept and includes all material facts, the amount of solution, rate of flow, and nature of reactions if present. All injections were supervised. The average amount given in each injection was 1 liter, which was equivalent to 50 grams of protein and 3 grams of sodium chloride, and the average time consumed in administration intravenously was 95 minutes or 10.5 c.c. per minute. Over 300 injections have been given. In the first 50 there were 7 reactions, 5 of which were pyrogenic and due to improperly cleaned infusion sets. In the last 250 cases there has not been a single reaction. We found that rapid injection may be followed by impaired utilization, and it is recommended that a rate of 500 c.c. per hour be adopted. No instance of thrombophlebitis was noted.

We have used this solution intravenously, subcutaneously, intramuscularly, and intrasternally with no ill effects. Reactions with any of the solutions are often due to improperly or poorly cleaned infusion sets. Only recently we ordered the solution for a postoperative case, and it was reported that after 10 c.c. the patient had a reaction. Another infusion set was obtained, and the remainder of the bottle, 490 c.c., was given without a reaction, definitely fixing the responsibility on the infusion set, probably the tubing.

The parenteral solutions of this type are not designed to replace feeding by mouth, but it is the rule, rather than the exception, that food is unacceptable, cannot be tolerated, or is contraindicated in the first few postoperative days.

Very few patients can maintain a nitrogen balance the first week after a major operation, and it is well to supplement the feeding with parenteral solutions (fig. 5). It is difficult to maintain nitrogen balance on parenteral protein solutions alone, nor does it supply adequate calories, but the combination of glucose and protein solutions will maintain the patient in equilibrium, often with a little balance on the positive side.

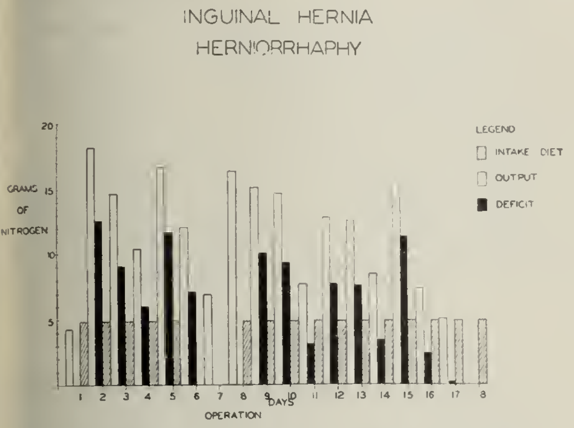

FIG. 5. Nitrogen balance in uncomplicated hernioplasty

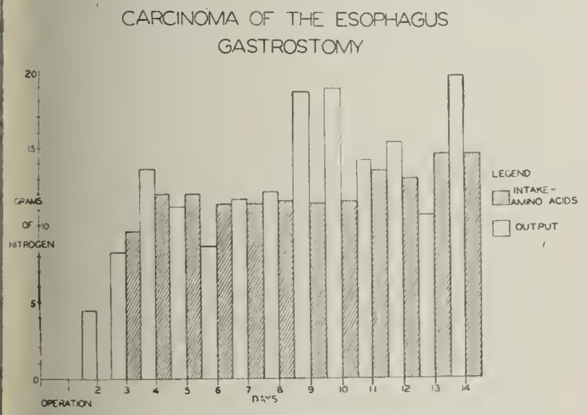

FIG. 7. Effect of amino acid solution intravenously on nitrogen balance. This was the only source of nourishment.

In several cases we withheld all food and attempted to maintain nitrogen balance by protein solutions alone. We could not do this consistently, but by the addition of glucose it was possible to maintain a balance indefinitely (fig. 6). Glucose supplies calories and relieves the demand on proteins. In several of the appended charts, the effect on nitrogen balance of protein, food, and glucose is graphically shown (fig. 7).

Just how long a patient can be maintained on intravenous injections has never been ascertained, but Brunschwig[18] reports a case of jejunal fistula following the removal of a cyst from the kidney in which intravenous nutrition was the only method of feeding for 8 weeks, by means of dextrose in saline, a protein solution, and vitamins C, B, and K hypodermically. Gelatine and blood transfusions were used occasionally. This is an exceptionally long period in which no food entered the stomach and invites speculation on the further use of parenteral feeding.

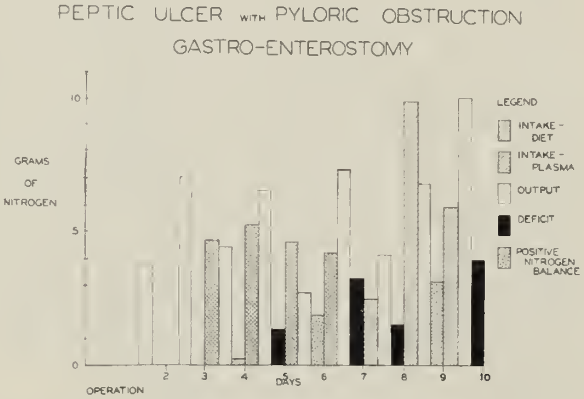

FIG. 6. Nitrogen balance with food and plasma

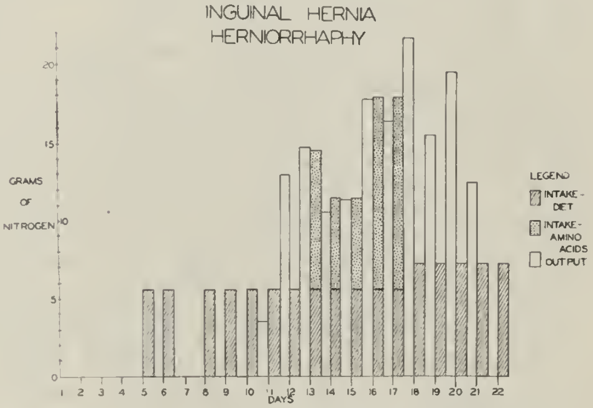

FIG. 8. Nitrogen balance with food and amino acids

Should we have occasion to treat a patient who cannot take food by mouth, or whose plasma protein level is low before or after a surgical operation, we would feel that he should have $1\frac{1}{2}$ liters of protein solution and the same amount of glucose solution in saline every 24 hours until he can take food, either liquid or semi-solid, in the usual manner; as he does resume feedings, the amount of parenteral fluids can be reduced (see fig. 8). In the amounts mentioned, sufficient salt is given. Eight grams is considered sufficient to meet the daily requirements, but the loss of sodium chloride by excessive vomiting or diarrhea, the constant evacuation of the gastrointestinal tract by a Wangensteen or Miller-Abbott tube will increase the need for salt, and 15 grams supplied daily does not seem to be too much. We are disposed to give too much rather than not enough, and glucose should be given in distilled water if the loss of salt is not excessive. Excessive salt may produce edema.

Glucose may aid in the conversion of proteins, and it no doubt spares the proteins and provides, quantity for quantity, as many calories.

In this day of the extravagant and unintelligent use of vitamins both by the lay public and the physician, one recommends the use of vitamins with some hesitancy, yet clinical experience justifies it in cases of hypoproteinemia. Most food contains ample vitamins, but if a patient derives his nourishment from fluids alone, largely by parenteral methods, the deficiency is apparent. The administration of well selected vitamins intravenously, alone or combined with glucose, saline or amino acid solutions, is sound therapy, and we endorse it.

Other solutions have been used to maintain the osmotic pressure in the capillaries or supply the much needed proteins.

Cohn and his associates at Harvard have reduced plasma proteins to several fractions, and they are making their way into clinical fields, but the expense of preparation does not permit their extended use. This applies as well to concentrated human plasma.

Gelatine solutions give promise, but their preparation is not simple or inexpensive. Much more work must be done experimentally before it can be given to the profession. Acacia solutions seem to have been relegated to the past, and probably will not be revived. The same can be said of pectin.

Choisser, Davis and White were the first to propose ascitic fluid as a substitute for plasma, but reactions were too frequent to continue its use in the opinion of Choisser and White; however, Davis has continued to use it with an enthusiasm that is shared by few others.

This paper purposely omits reference to the Hartman, Ringer and other buffer solutions, since they involve a discussion of water balance, which is beyond the scope of this paper.

SUMMARY

In institutions where studies have been made in protein levels and nitrogen balance, such studies have been consistent in revealing that a surprisingly large number of patients have had low protein levels both before and subsequent to operations, and this is particularly true in surgery of the alimentary tract. Slow healing and separation of wound surfaces have been laid at the door of such deficient states, which is not surprising in view of the recent reports of the amazing cures of peptic ulcers and ulcerative colitis following the use of amino acid solutions. We must accept the statement that proteins play a major part in our reparative processes.

We have probably unwittingly overdone the administration of glucose and electrolyte solutions to the neglect of the protein solution. We are on the threshold of a strong trend toward the latter, justified by experimentation and clinical use in steadily increasing numbers.

It is not necessary to demand nitrogen balance studies or even an estimate of the plasma proteins in every patient, but the time has arrived when we must go into the fluid balance and the plasma protein estimation in many of our patients. To fail to do so is to leave out of

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FUNDAMENTALS OF CHILD PSYCHOLOGY IN EVERYDAY MEDICAL PRACTICE*

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Washington

TODAY we in the medical profession are crossing the threshold of a new usefulness to our fellow man as we apply in our daily contacts with parents and children the important recent discoveries of our psychiatrists and other students of child psychology. It is generally expected of us by the public that we shall be prepared to perform this function wisely and effectively. Much lay publicity has been building up such an expectation and it is surely in the best tradition of our profession that we shall make the utmost of the opportunity.

The purpose of the present discussion is very briefly to review the newer philosophy of child management and to indicate its specific application to the most common problems of everyday medical practice.

By way of establishing a comparison it is reminded that our old traditional attitude toward children has centered about the idea that they are born messy little animals who must be converted into cherubs by iron repression of their sexual instinct and stern squelching of all their aggressive tendencies that happen to be inconvenient or troublesome to adults. When this ideal was attained in practice the product was a desexualized, meek, anxious child who was proudly exhibited as a work of parental art. If in later years he turned out to be a timid, impotent neurotic, ridden by a host of compulsive fears, no one cared much unless he became a public charge. His timidity was calmly exploited by others, and his sexual impotence was often admired as a sign of high moral attainment. If his inner conflicts and frustrations resulted in crime or psychosis the matter was sadly dismissed as one of life's incomprehensible mysteries.

In contrast to this traditional concept of child training we are at last recognizing that a baby is a real human being, right from the start, and as such is entitled to the same fundamental rights articulately demanded by mature adults. He requires expression of all of his instinctual drives and functions, he enjoys affection and approval, and he rebels at harsh treatment but is readily led into good behavior patterns when his needs and limitations are understood. He is capable of developing a rugged inner strength of character if allowed reasonable freedom to test his instinctual needs against the practical realities of life. Character acquired in this way has about it a human and flexible quality that makes it an agreeable and useful tool in life, rather than a hateful strait jacket. It is becoming increasingly clear that character which is founded upon terrified submission to uncomprehended adult rituals is of a weak and dangerous sort, painful to the child, productive of vicious escape into phantasy, and in the long run is no serviceable character at all.

It is now generally recognized that every physically sound baby is potentially a fine human being. The only thing that can prevent this realization is his parents. If he turns out a mess it is they who have done the messing-up, however strong their loving sentiment and good intentions. Accordingly, we in the medical profession ought to have some genuine personal concern over outlining parental qualifications and striving to see that they are met.

First of all, it may be accepted as axiomatic that only emotionally mature individuals are good risks as parents. The best test of emotional maturity is marriage itself. The test can be said to have been passed if the relationship is still warm and sound a year or more after marriage. This is the test of reality. Those who can not pass it should not have children unless successful adjustments are worked out through psychiatric assistance. This waiting period for newly married couples should become a definite element in our improving concepts of marriage and parenthood. It is a plan fully justified by tested principles of prophylactic medicine. It is made readily possible through available contraceptive technics, and the wisdom of it is easily perceived by most young people of our present generation.

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* Read before the Society, March 20, 1946.

When we are consulted by a young couple with a baby on the way we miss a great opportunity if we do not at once undertake some missionary work in suggesting reading to guide the prospective parents in their attitudes and responsibilities toward the child. There are many fine recent publications available, but one in particular should be considered. I refer to the manual "Babies Are Human Beings" by Drs. Anderson and Mary Aldrich. This little book seems to me one of the truly great classics of our literature, and I have found my enthusiasm for it to be shared by every colleague and every patient who has read it. It is a pleasure to report that many local obstetricians and pediatricians recommend it routinely. To do so is not only a public service but also an act which promotes a warm feeling in the relationship between doctor and patient.

The Aldrich book covers the general philosophy of infant management and considers in detail the special problems of the first year of life. The job is done so superbly that I would presume to make further explanation here. Get the book and you will see what I mean.

With each passing year of clinical experience in marriage counseling and child guidance I gain added conviction that no printed word will ever equal in importance the matter of a good sound emotional relationship between the parents. When they have a deeply affectionate regard for each other, expressed in a mutually satisfying sexual relationship, they generally display toward children a balanced affection and a tolerant, flexible discipline that creates few problems. Also they are responsive to professional advice when it becomes necessary. On the other hand, when husband and wife live in a state of perpetual sexual antagonism, their attitudes toward children take on abnormal intensities because children play them against each other and feel highly insecure perched in the middle. The child finds serene sexual identification of himself impossible and links sexual characteristics with hostility and insecurity. Also, highly antagonistic parents are almost powerless to make really effective use of professional advice when it is offered.

If we turn to the specific childhood behavior problems that are most often the cause of parental concern we must consider feeding, bowel and bladder training, thumb-sucking, masturbation, sexual exhibitionism, tantrums, stealing, lying, destructiveness, stammering, phobias, and either excessive shyness or unusual aggressiveness toward other children.

As to the principles involved in infant feeding and excrementory training I again make enthusiastic reference to the previously mentioned book by Aldrich. When bed-wetting recurs in an apparently trained child, it is a sure sign of some severe intercurrent frustration, usually punishment over masturbation or a violent jealousy. This is a spot where professional aid is sometimes particularly valuable.

Thumb-sucking and masturbation are strictly normal within wide limits and should never be dealt with harshly. Their importance should not be overvalued. They become significant only when linked with severe parental disapproval or when substituted by a frustrated child for other emotional needs that have been denied.

Mutual sexual exhibitionism among children is nothing to get excited about. It is an expression of a natural curiosity. It becomes pathologic only when linked through disapproval with strong motives of defiance and hostility.

Tantrums, stealing, lying and great destructiveness are all unfailing signs of excessive hostility and poor adult management of the child's aggressive impulses. This group of problems may have a complex and obscure background, but they will yield to patient professional study and the necessary parental coöperation.

Stammering is one of the most important of all danger signs in early childhood and appears rarely to be understood. It is an anxiety reaction always brought on by violently repressed hostility toward someone in the family. Unless resolved it may appear in adult life not only as a speech defect but also quite regularly as a companion of masked sadism and sexual impotence. It is a major problem when a psychiatrist wrestles with it in the adult. Taken promptly in childhood it may often be cleared up within a short time. Treatment should never be deferred.

Severe childhood phobias are unfailing signs of frustration and insecurity. They are usually not to be taken at face value. They merely symbolize a deeper and very tragic fear that may persist throughout life if not resolved. Tics and other compulsive mannerisms have a similar significance. Professional aid is often very necessary to unravel these childhood disorders when they are persistent.

Children who are excessively shy or who are constantly hostile and violent toward other children are sure to have been severely frustrated in the unfoldment of their personality needs. Professional aid is generally advisable, and the longer it is put off the more difficult is the solution.

Clinical experience has led me to a couple of personal observations that I believe should be given wide circulation. I have noticed, over and over, that children of less than 3 or 4 years nearly always find it impossible to make a smooth emotional adjustment to a new baby in the family, even with good adult management. The reason is not hard to discover. The child of less than 3 or 4 is still very much a dependent baby, and he feels antagonism toward a competitor. On the other hand, the well raised child who has reached this age has advanced beyond babyhood, has lost much of his dependent attitude, and is taking active pride in becoming independent. He has begun to form friendships with other children and has more mature play interests. Therefore, he does not look upon a new baby as a real competitor but may rather find that the baby emphasizes his own sense of advancement toward adult independence and security.

The other matter to which I wish especially to call attention is the observation that if parents are to prevent a wall of fear and embarrassment from growing between them and their children as to matters of sex they must break down their own rigid fears and face the child's sexual curiosities and interests promptly and with a minimum of fear and tension. This is a big order for most parents, but the vicious cycle of generation-to-generation anxiety will never be broken unless an increasing number of courageous souls have a real try at it. And if they do it often turns out to be a lot easier than anticipated. I would emphasize that children want to know above all things about the true meanings of sexual differentiation and function, not just about reproduction. They want to know about sex anatomy, about their own sexual feelings, about the integration of sex with everyday life. They are sure to learn the sexual language and concepts of furtive child companionship, and parents should anticipate this, introducing all the one-syllable Anglo-Saxon words together with accurate definitions. Also parents should interpret sex in a simple, socialized manner and contrast this with the smirking, obscene interpretations of furtive playmates. Only in this way can a parent retain any real power to have a constructive influence upon a child's unfolding

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FREE SKIN GRAFTS

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IT IS generally accepted that the human organism is a remarkably constructed and highly efficient machine, the constituent parts of which are endowed with special work or functions. The skin is no small contributor to this phenomenon. Its functions are protection, heat regulation, sensory perception, and excretion. Also accredited to skin is that of absorption, but for all practical purposes it is probably better to classify this as a property.

It is impossible to estimate the degree of punishment (normal trauma) this protective covering absorbs in average daily life, yet this extraordinary indulgence makes its use in plastic surgery invaluable in reducing morbidity and is often lifesaving.

Skin will retain its viability in a refrigerated state up to 3 weeks. When lifted from its bed and placed on a recipient site as a free graft it is capable of nourishing itself from tissue fluids until the seventh to the tenth day, when its own capillary circulation is established with that of the parent tissue. On the other hand, skin will not withstand supportive tension. This is best exemplified when the edges of a wound are forcibly united by suture. Invariably the result is the permanent stepladder-type scarring, the sutures having produced pressure necrosis.

When and wherever surface epithelium (including mucous membrane) is completely lost, that is, below the level of the epithelial pegs, it must be replaced. Failure to do so interferes with its normal functions with proportionately direct effect on the individual. The most notable example is the third degree burn with concomitant shock, and in turn the toxic state, vasomotor imbalance, hemoconcentration, anoxia and death.

From the above can be seen the fallacy in claiming superiority of one method of treatment for surface tissue loss over another. Suffice it to say that, whatever the cause in subtotal loss, providing epithelial remnants are preserved during the course of treatment, there will be full and total regeneration. This immediately excludes the use of drugs coming under the heading of protein coagulants. Conversely, in total epithelial loss regardless of technic, medication or surgical acumen, healing will take place by granulation and scar or one must resort to skin graft. The urgency of the latter depends on the size of the area involved. The tests for degree of skin loss can be elicited first by the character of healing; the presence of granulation tissue precludes full epithelial regeneration. Secondly, microscopic section will reveal the presence or absence of papillae, without which normal epithelialization and regeneration of hair follicles, sweat and sebaceous glands are impossible.

The versatility of skin employed as a free graft is at times amazing, not only because of its adaptability to strange sites of transplantation, ability to thrive and eventually reassume its destined function, but the extenuating circumstances demanding its use when no other corrective procedure is available. Specifically, the reconstruction of the labio-alveolar sulcus in the mouth, a site that can be kept neither dry nor clean, may be mentioned. In extreme cases, as seen in figure 1, following gunshot injury, extensive loss of bone, and obliteration of the sulcus, a prosthetic dental restoration would be impossible. Equally impossible would be the amount of mucous membrane necessary for similar reconstruction with no advantage to be gained by its use.

Figure 2 shows the result following massive bone graft and available alveolar ridge following restoration of the sulcus by skin graft. The area extends from behind the third molar area on the left to the right cuspid tooth.

To a lesser degree but under no less ideal circumstances figure 3 shows another intraoral skin graft neces-

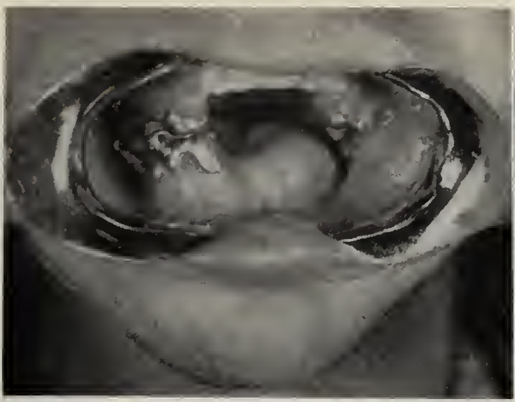

Fig. 1. Reflection of mucous membrane on level with crest of restored alveolar process (bone graft).

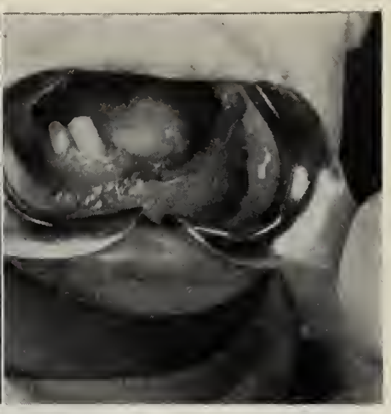

Fig. 2. Same case as in figure 1 after reconstruction of the sulcus by massive skin graft covering alveolar ridge, the reflection and the cheek lining.

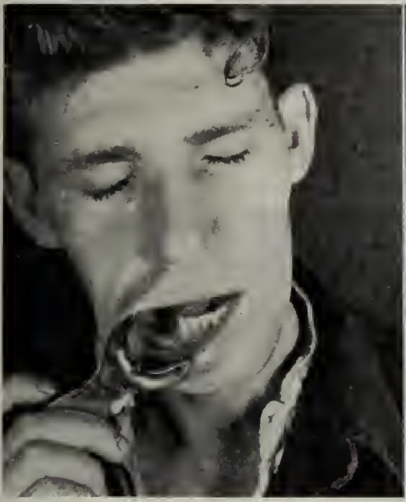

Fig. 3. Restoration of ridge by skin graft

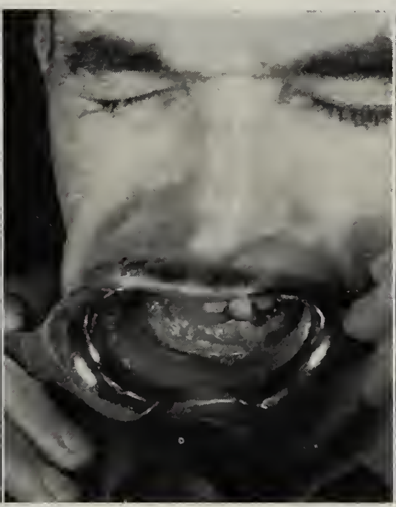

Fig. 4. Sulcus and ridge restored by free graft

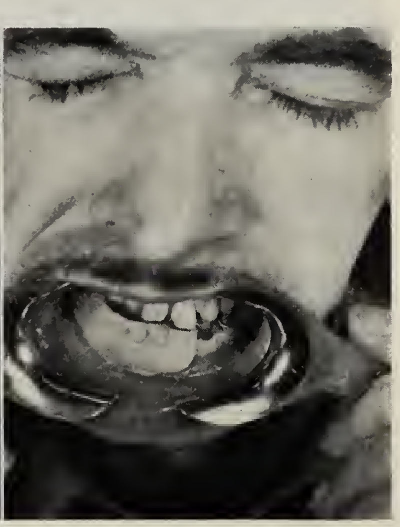

Fig. 5. Same as figure 4, with denture in place

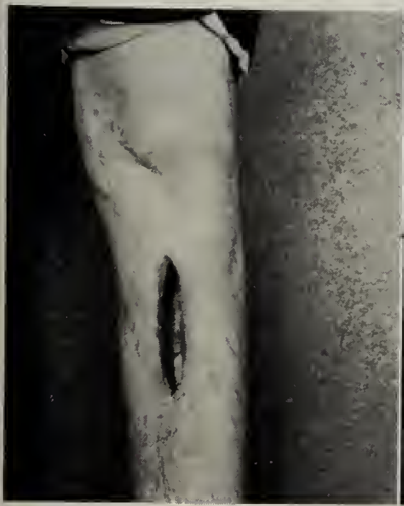

Fig. 6. Healed osteomyelitic cavity lined by skin. Will require bone graft and full coverage.

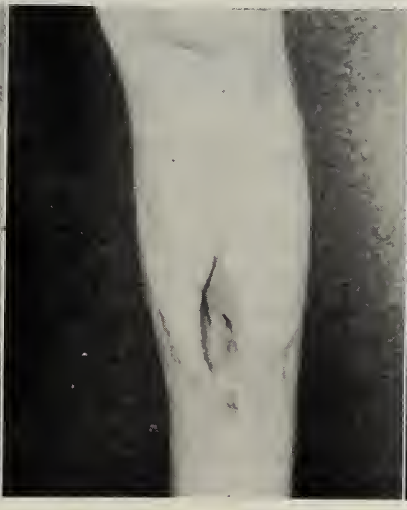

Fig. 7. Healed cavity with lining. May not require further surgery.

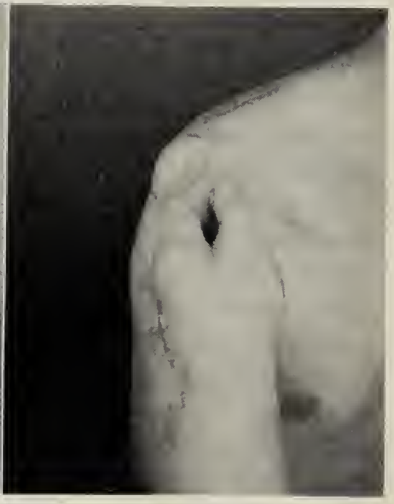

Fig. 8. Extensive cavity head of humerus lined by skin

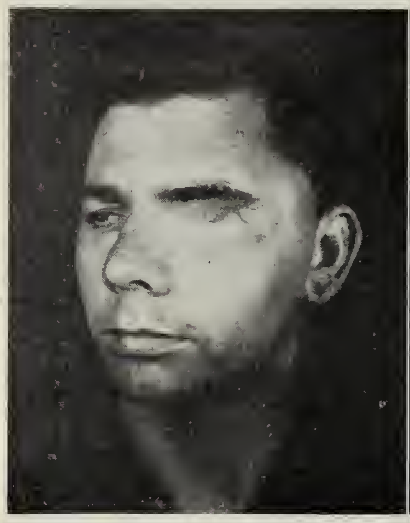
FIG. 9. Obliterated orbital cavity

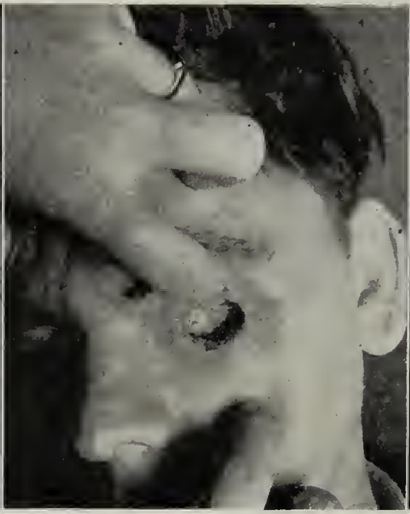
FIG. 10. Reconstructed orbit with one-piece free skin graft

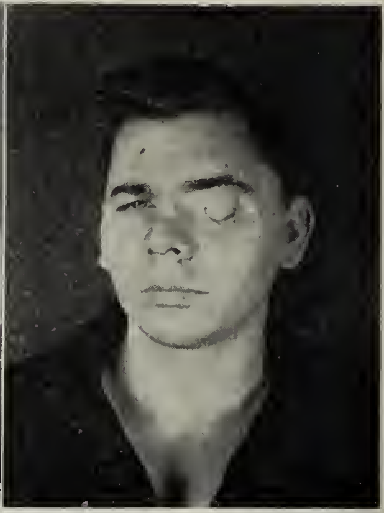
FIG. 11. Plastic conformer used until final healing, revision of canthi and construction of final plastic eye.

sary to make a prosthesis possible.

Figures 4 and 5 show an extensive intraoral skin graft and the denture in place.

The immediate insertion of the denture insures maintenance of the sulcus, prevents undue contraction during final healing, and is much more acceptable to the patient than prolonged use of a stent. The latter is bothersome and serves no other purpose, whereas the denture serves the dual role of maintaining the sulcus and as an aid in mastication.

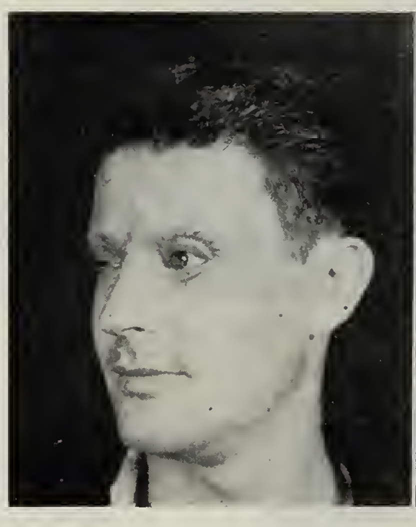
FIG. 12. Ectropion of upper and lower eyelids following third degree gasoline burn.

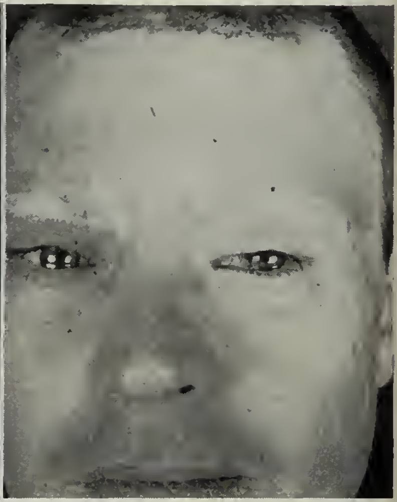
FIG. 13. Correction by free full-thickness skin grafts.

The free graft lends itself admirably in halting the progress of chronic osteomyelitis, particularly following compound fracture. Here again it is difficult if not impossible to maintain asepsis. Following saucerization the free graft is employed as a protective covering until such time as the septic process is controlled and the bone graft is deemed safe. Here the graft is intended only as a healed dressing. The plan for subsequent bone graft must necessarily include provision for adequate coverage by use of contiguous tissue or a tubed graft from another part of the body. Figures 6, 7 and 8 are examples of its utility in these conditions.

Orbital reconstruction is made possible by use of the free graft. Figure 9 shows the case at the start of reconstruction, a fusion operation having been performed elsewhere. By division and stent graft the socket was reëstablished

(*Continued on page 307*)

THE USE OF STREPTOMYCIN IN ACUTE MILIARY TUBERCULOSIS

Report of a Case

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IN THE search for a chemotherapeutic substance which would be effective against the gram negative bacteria, Waksman and Woodruff[1] came upon streptothricin (from the Actinomyces lavendulae) as the first substance to show promise in the treatment of disease caused by these organisms. This was soon followed by streptomycin[2] (from Actinomyces griseus) which was found to be free of the toxic properties of streptothricin and which had a higher bactericidal and bacteriostatic action. The outstanding finding was that Mycobacterium tuberculosis was much more sensitive to streptomycin[3] than to many other substances previously studied (promin, diasone, streptothricin, etc.). This immediately stimulated investigation in this new method of approach in the treatment of tuberculosis.[4] Other organisms found to be successfully attacked experimentally include Brucella abortus, Eberthella typhosa, Salmonella, Shigella, Pasteurella tularense, Klebsiella pneumoniae, Pseudomonas aeruginosa, Proteus vulgaris, etc. Subsequent clinical investigation has been limited, but studies so far reveal disappointing results in undulant fever, although somewhat encouraging results in tularemia, dysentery, K. pneumoniae infections and, in Reimann's cases, typhoid fever.[5] Reimann[6] states that no evidence of benefit seemed to be derived in tuberculous meningitis or in H. influenzae,[7] but in the latter disease streptomycin coupled with sulfadiazine has been proposed as the possible optimal treatment.

Excretion and absorption studies on streptomycin reveal that this antibiotic behaves like penicillin in that it is rapidly absorbed following parenteral administration and that it is rapidly excreted in the urine, only about 2 per cent being found in the feces. A point of difference exists, however, in that the blood level of streptomycin seems to remain high for a longer period following intravenous administration than does penicillin, detectable amounts being present for 6 hours as compared to $2\frac{1}{2}$ to 3 hours with penicillin, even though the intramuscular method was used for the latter agent.[8] It is comparable to penicillin, also, in that small amounts diffuse into the cerebrospinal fluid, even though a high blood serum level exists (1 to 2 micrograms in spinal fluid with levels of 25 micrograms in blood serum). It is detectable, however, in ascitic, peritoneal and pleural fluids in amounts closely approximating the blood serum, and it has been found to be present in bile, ocular fluids, fetal blood and amniotic fluid following parenteral administration. Streptomycin has been given intravenously, intramuscularly, subcutaneously, and orally both continuously and intermittently for long periods to humans without toxic effect comparable to that found in experimental animals. Studies on liver and renal functions in humans after both massive single injection and repeated moderate injections reveal no evidence of reduced function of these organs.[9] Immediate reaction in the form of chills and fever, cutaneous toxic reactions (generalized flushing, dermatitis, urticaria), joint pains, nausea and vomiting, have been noted.[9] These reactions have not appeared in severity necessitating the cessation of the treatment, however. Because of the possibility of venous irritation and thrombosis, and the fact that intramuscular injections seem to produce a more prolonged therapeutic level, there seems to be no valid indication for intravenous administration.[10] The oral method is reserved for infections within the gastrointestinal tract, since passage through the wall of the gastrointestinal tract is difficult and adequate blood serum levels are not obtained. It is therefore suggested[9] for infections involving both the blood stream and the gastrointestinal tract that the oral and parenteral administration is necessary.

Information available on the clinical use of streptomycin is so limited that a report on its use in a patient with acute miliary tuberculosis, in which the meningeal form predominated, seems justified at this time.

Report of Case

O. R. V., a 28-year-old male officer was admitted to the hospital on July 5, 1945, having been returned from overseas because of transient pleural effusion. The history indicates that in February of 1945 he developed a mild upper respiratory infection but continued on duty. On March 5, 1945 a pleuritic type of pain developed in the lower right chest with associated dyspnea and weakness, and he was admitted to a hospital where a diagnosis of right pleural effusion was established. After 22 days' hospitalization he was returned to duty, but pain, weakness, and fatigability with an afternoon, low-grade temperature continued. He was then readmitted to the hospital on May 16, 1945. At this latter installation X-ray films of the chest showed evidence of thickened pleura in the right lower lung field, but the previously described pleural effusion was not evidenced. The sputum was negative for acid-fast bacilli, and the sedimentation rate was reported to be 35 mm. per hour. At this time he was returned to the Zone of Interior. On the first admission to this hospital the physical examination was recorded as essentially negative. The laboratory studies showed a red blood cell count of 4,600,000 and hemoglobin determination of 90 per cent; the white blood cells totaled 4,600, with a normal differential. The sedimentation rate was 2 mm. per hour, the urinalysis revealed no abnormality, and the Kahn test was reported negative. A roentgenogram of the chest at this time showed blunting of the right costophrenic angle, but the lung parenchyma was clear in all areas. During this initial period of observation he remained afebrile and felt well. Shortly thereafter a sick leave was obtained, from which he returned in 30 days for reëvaluation. At this time, since the physical examination, X-ray films, blood count, and sedimentation rate were repeated and were consistent with the original studies, he was discharged from the hospital with a diagnosis of chronic adhesive pleurisy.

On October 4, 1945 he was readmitted to this hospital and the interval history obtained revealed that about 3 weeks prior to this admission he began to have fever, afternoon headaches, anorexia, irritability, and easy fatigability. About 1 week later it was noted that the headaches were becoming more severe, that there was an associated temperature elevation to 100°F. or 101°F. each day, and that nausea and vomiting were accompanying the headache. These symptoms were the basis for readmission to the hospital. Physical examination at this time revealed a well developed, well nourished, white male in acute distress complaining of severe generalized headache and photophobia. The temperature was 102°F., the pulse rate was 110 per minute, and the respiratory rate 20 per minute. There was no nuchal rigidity, the naso-pharynx revealed no abnormality, and there was no skin rash. The extraocular movements and the ocular fundi appeared normal. The chest was clear in all areas except for diminished breath sounds at the right base. The thyroid was not palpable and there was no adenopathy. No significant cardiac abnormality was noted, and the blood pressure was 120/80–75 in each arm. Examination of the abdomen was negative, there being no areas of tenderness or rigidity, and neither the liver nor spleen was palpable. The external genitalia revealed a hard tender mass in the lower pole of the right epididymis, which had been noted by the patient 3 days before. The remainder of the genitalia were normal. There was no urethral discharge or history of one. The prostate appeared normal to digital examination. The reflexes were present and equal, there being no pathologic reflex present. An X-ray film of the chest revealed no change from the previous films, in that the blunting of the right costophrenic angle was present but the parenchyma was clear. A roentgenogram of the skull revealed no abnormality. A brucella antigen skin test was negative. The red blood cells numbered 4,400,000 with 85 per cent hemoglobin; the white blood cells totaled 17,500, with 69 per cent neutrophiles, 1 per cent stab forms, 27 per

TABLE 1

Spinal Fluid Examinations

DATE		CELL COUNT		SUGAR	CHLORIDES	PROTEINS
		Total	Lymphs			
Normal		1–3		40–80	720–750	20–30
October	12	9	9	58	726	40
	17	107	107	30	660	49
	18	142	142	20	594	48
	19	107	104	20	561	46
		105	52	32	594	36
	20	441	71	26	577	38
		210	89	33	561	38
	21	220	99	32	594	34
	22	752	75	36	594	54
		214	100	24	594	48
	23	920	82	26	577	95
	24	341	85	31	610	98
		631	54	36		108
	25			25	610	90
		360	14	27	610	116
	26	291	47	21	594	111
		302	19	20	643	110
	27	261	28	27	627	111
	28	102	67	26	625	110
	29	230	69	22	660	97
	30	210	90	24	627	100
	31	97	63	17		112
November	1	125	59	14	643	121
	2	143	66		643	121
	3	106	59		660	126
	4	160	64	19	643	121
	5	155	62	15	676	106
	6	165	70	20	670	112
	7	150	65	19	676	115
	8	140	60	16	689	128
	9	133	70	23	672	78
	10	140	40	18	678	69
	11	150	60	23	720	72
	12	160	70	26	710	67
	13	82	33	20	710	
	14	77	40	28	699	124
	15	90	50	32	660	125
	16	200	67	34	668	122
		219	41	37	660	123
	17	60	35	25	668	122
	18	92	58	23	701	122

cent lymphocytes, 2 per cent monocytes, and 1 per cent eosinophiles. The urine was normal and the Kahn test negative. The sedimentation rate was 22 mm. in 1 hour. Repeated blood cultures were subsequently reported as showing no growth. The malaria smears were negative. Blood chemistry studies revealed sugar, chlorides, non-protein nitrogen, creatinine, and carbon dioxide combining power to be within normal limits.

Because of the history of pleurisy with effusion and the finding of the mass in the right epididymis the possibility of tuberculous meningitis was suspected. Spinal tap done 5 days after admission revealed a clear fluid that was under no increased pressure. Laboratory studies of this fluid showed 9 cells, all lymphocytes, protein content of 40 mg., sugar 58 mg., and chlorides 726 mg. There was no pellicle formation, and the smears and cultures were subsequently reported negative. Symptomatic relief of the headache was obtained by codeine and aspirin but not by Gynergen or nicotinic acid. The temperature remained elevated from 100°F. to 102°F., and a relative bradycardia began to appear. No neurologic changes became manifest until the thirteenth hospital day, when nuchal rigidity grade 2 (on a basis of 4) became evident with associated diplopia, vertical nystagmus, minimal mental clouding and a positive Kernig's sign. No other pathologic reflexes were elicited. Spinal puncture at this time revealed the pressure to be 300 mm. of water and the fluid to be cloudy. Laboratory study of this fluid showed 107 cells, all lymphocytes, sugar 30 mg., protein 49 mg., and chlorides 660 mg. There was no pellicle formation at this time, and no acid-fast organisms were seen. From the clinical findings and the spinal fluid chemical changes (increased protein and decreased chlorides) it was felt that the diagnosis of tuberculous meningitis was tenable, and it was on this basis that streptomycin therapy was instituted. Spinal fluid examination was done daily, and within a short time the pellicle made its appearance, from which the acid-fast organisms resembling Mycobacterium tuberculosis were obtained. The Levinson test became, and remained, positive. Table 1 reveals the results of the subsequent examinations of the spinal fluid.

The streptomycin (which was instituted 14 days after admission and which was continued until death) was given both intrathecally and intramuscularly in dosage as shown in table 2. It should be noted that for the first 10 days streptomycin was given intrathecally in dosage of 50,000 units once a day and intramuscularly in dosage of 50,000 units every 3 hours. From then on the dosage was 25,000 units intrathecally daily and 50,000 units intramuscularly every 3 hours. The total streptomycin given amounted to 10,000,000 units intramuscularly and 1,050,000 units intrathecally.

Lethargy and semistupor prevailed throughout the last 4 weeks of the illness, although at times mild response was obtained to simple orders. The moderate nystagmus became more pronounced, and a left facial paralysis developed and persisted. Neurologic examination done each day failed to elicit anything other than the nystag-

TABLE 2

Streptomycin Dosage

DATES	INTRATHECAL*	INTRAMUSCULAR†
Oct. 18 through Oct. 27	50,000 units	50,000 units
Oct. 28 through Nov. 8	25,000 units	50,000 units
Nov. 9 through Nov. 14	25,000 units	25,000 units
Nov. 15 through Nov. 18	25,000 units	
Total	1,050,000 units	10,000,000 units

* One injection per day
† Given every 3 hours

mus, the nuchal rigidity, and the positive Kernig's sign. The deep reflexes were hyperactive but equal. The ocular fundi remained normal, at no time showing any choroidal tubercles. The lung parenchyma remained clear at all times to both physical and X-ray examinations. The blood pressure vacillated from 120/80–75 to 170/90–85 and seemed to correspond to the degree of intracranial pressure as evidenced by manometric readings of the spinal fluid, which in turn fluctuated from 250 to 600 mm. H_2O There were 2 episodes of microscopic hematuria, but renal function as evidenced by urinary output and urinalysis remained good. The red blood cell count and hematocrit remained normal throughout, and repeated blood chemical studies stayed within normal limits. Sedimentation rates never went above 22 mm. per hour, and the total white blood cell count averaged about 10,000. The cephalin cholesterol flocculation remained negative, and the icterus index and van den Bergh showed no increase. Nourishment was supplied by mouth when coöperation was obtained, but this was fortified by the use of intravenous glucose and amino acids as well as parenterally administered vitamins and liver extract. The elevated temperature, the lowered pulse rate, and the semistupor continued until the last 36 hours, at which time deep stupor developed with associated generalized clonic and tonic contractures. Terminal hyperpyrexia to 108°F. (rectally) was present just prior to death.

The autopsy was performed by Major Elmus D. Peasley, M.C. The body was that of a fairly well developed and well nourished white male, measuring 68½ inches in length and estimated to weigh from 125 to 130 pounds. There was no rigor and only slight postmortem lividity. The ears were negative. The pupils measured 6.5 mm. (right) and 5 mm. (left). The peritoneal cavity was smooth and shiny throughout, with no free fluid. The left pleural cavity was smooth and moist, with no excess fluid or adhesions. The right was obliterated by fibrous adhesions, which were most dense at the base. The pericardial cavity contained approximately 20 c.c. of clear, straw-colored fluid. The right lung weighed 370 Gm., the left, 390 Gm. Both lungs showed moderate dependent congestion, with no evidence of consolidation. The pleura of the right lung was ragged throughout. The bronchi contained a small amount of bloody fluid. After fixation both lungs were sectioned serially in thin layers. No evidence of active tuberculosis was found. There were 2 lesions at the hilum of the right lung, measuring 2 x 1 x 1 cm. and 0.7 cm. in diameter respectively, which were in close proximity to the primary bronchi. These lesions showed capsules which were partially calcified, with the centers consisting of caseous doughy material, which was yellowish-tan. X-ray films of the lungs were reviewed in view of these lesions and showed no hilar changes that could be considered abnormal. The heart weight was 290 Gm. No abnormalities were noted. The myocardium appeared normal. The coronary arteries were smooth and free from sclerosis throughout. The aorta and its branches were elastic and had a smooth intima. The spleen weighed 125 Gm. It was of grayish-plum color with a slightly wrinkled capsule. On cut section, the pulp was of normal consistency and did not scrape away. No tubercles were seen. The liver weighed 1,360 Gm. The capsule was smooth. The cut section was of uniformly brown color. The gall bladder was filled with dark bile. There were no stones. The ducts were patent. The pancreas was of normal size and appearance. No abnormalities were noted in the adrenals. The mucosa, particularly in the body of the stomach, showed numerous small hemorrhagic spots. The small intestine contained a small amount of brown mucoid material. No lesions were noted in any part. The colon was slightly distended with gas and contained a few firm fecal masses. The appendix revealed no pathology. The kidneys weighed 125 Gm. and 165 Gm. Both had a smooth capsule which stripped readily, leaving a smooth surface. There were fairly numerous small brown stones measuring up to 0.3 cm. in diameter in the calyces. The cortex measured 0.6 cm. in thickness and was not unusual. On the surface of one kidney there were 2 white spots measuring 0.1 cm. in diameter which were possibly tubercles. The seminal vesicles and prostate were normal. The right epididymis measured 3 x 1 x 1 cm. and was very firm. On cut section it was grayish-white. It was believed to be tuberculous. The brain weighed 1,520 Gm. There was practically no fluid over the surface. The convolutions were flattened, with moderate severe congestion. There were a few scattered small white spots in the meninges along the Sylvian fissure, which appeared to be tubercles. None were seen over the vertex of the brain. When the brain was removed there was a rather copious white exudate about the brain stem, especially over the inferior surface of the cerebral peduncles and pons extending anteriorly to include the optic chiasma. There were a few scattered tubercles on the inferior surface of the cerebrum posteriorly, as well as a few scattered ones over the cerebellum. After fixation the brain was sectioned coronally and showed considerable distention of the ventricular system. In the mid portion of the left thalamus just medial to the internal capsule there was an irregular, softened area measuring approximately 1.5 x 1 x 1 cm. This area was slightly discolored. Bone marrow taken from the vertebra and rib showed it to be normally red.

In summary, there was an extensive typical tuberculous basal meningitis with a few tubercles scattered over the cortex. A small area of degeneration was noted in the left thalamus. There was complete obliteration of the right pleural cavity and inactive hilar tuberculosis in the right lung. The right epididymis was large and firm and grossly appeared to be tuberculous. Tuberculosis of the kidneys was suspected, but numerous stones were found which accounted for all the symptoms and findings. The right lung must be indicated as the primary source of the infection even though no active lesions could be found.

Microscopic sections of the dependent portions of the lung showed extensive congestion and edema with considerable hemorrhage. There were many alveoli that were filled with polymorphonuclear leukocytes. There was an evident dilatation of many of the bronchioles. Many of the small bronchioles were filled with an exudate similar to that found in the lungs. One section of the lung showed no fluid or hemorrhage, but there were scattered typical miliary tubercles. The liver was well preserved, with no evidence of vacuolization or toxic injury. There was an occasional small tubercle. Except for the presence of a few scattered miliary tubercles which approximated the size of malpighian corpuscles, no unusual findings were present in the spleen. In the cortex of one adrenal there were a few areas of tuberculous reaction with extensive caseation necrosis and with only a few giant cells. A few of the renal glomeruli were partially hyalinized or showed a thickening of Bowman's capsules. There was an occasional subcapsular tubercle. The convoluted tubercles revealed the usual postmortem cloudy swelling. In the medulla an occasional tubule was seen to contain calcium. The prostate was negative except for a tubercle beneath the epithelium of the attached bladder tissue. There was marked typical tuberculous inflammation with large areas of necrosis in the epididymis. Bone marrow from the vertebra was essentially negative except for the presence of one atypical tubercle. This was shown as an area of fibrosis with a few epitheloid cells. The pituitary gland was negative except for one area which consisted of a few epitheloid cells and a few round cells which were interpreted to be an atypical tubercle. Section from the brain stem showed extensive tuberculous exudation and inflammation in the meninges with involvement of the proximate brain tissue. Considerable caseation was present. The cerebellum showed a well developed tubercle in the pia which had involved the adjacent cerebellar cortex. In the thalamus there was an irregular area of degeneration with partial liquefaction. There were numerous phagocytic glial cells, some of which were finely vacuolated. No pigmentation was seen, and no capsular formation was noted. The blood culture remained sterile.

In summary, microscopic examination showed the presence of generalized miliary tuberculosis of which the tuberculous meningitis was only one portion. There was still no proof of the primary site, but there was no reason to consider it other than the right lung on presumptive evidence. The degeneration of the thalamus was consistent with the occlusion of the blood supply, but the exact vessel affected was not discovered. There was no evidence of any toxic injury produced by the streptomycin.

COMMENT

The antibiotics have as one of their outstanding virtues the relative freedom from toxicity. This has been the clinical experience of those most widely acquainted with their use. The case herein presented, in which over 11 million units of streptomycin was given in 27 days without any apparent deleterious effects, fits in with observations made by others. For instance, Heilman et al[9] quote a patient who received 150 million units in 42 days without evidence of renal involvement even though the patient had but 1 kidney. During the course of treatment of our patient the 2 bouts of hematuria caused speculation as to whether the streptomycin was at fault or whether a possible tuberculous focus in the kidney was the factor. Autopsy revealed millet-seed stones in both kidneys which answered the question. Whether or not the streptomycin was the exciting agent for the lithiasis is debatable, but it seems more logical to assume that it was due to renal stasis as a result of long-continued bed rest. Clinical analysis of these stones showed them to be composed of calcium-magnesium-phosphate.

Lack of coöperation on the part of the patient, because of lethargy and semistupor, and the seriousness of his illness precluded renal or hepatic function studies, but neither the gross nor microscopic sections of these organs at autopsy revealed any evidence of pathology that could be attributed to streptomycin. It is of interest that the meninges showed no gross evidence of reaction even though intrathecal streptomycin had been given daily for 27 days. Streptomycin was used intramuscularly also in this patient, although it was realized that only small quantities would cross the meninges; however, it was continued because of the presence of the tuberculous epididymis and for possible action on any other focus that might be present but not recognized as evidenced by the autopsy, which revealed the generalized miliary tuberculosis and which could not be diagnosed clinically because of its extremely early state. The intravenous amino acids, given to the extent of 50 to 65 grams per day, in conjunction with the feedings by mouth were sufficient to keep the plasma proteins within normal range. All blood chemical studies, urinalyses, and red blood cell counts remained within normal limits throughout the illness, as did the cephalin cholesterol flocculation test, the icterus index and the van den Bergh reaction. Final proof that tuberculous meningitis existed was revealed by a late report which showed that both urine and spinal fluid culture and guinea-pig inoculation were positive for tubercle bacilli.

SUMMARY

A case of acute miliary tuberculosis is presented which was unsuccessfully treated with streptomycin.

The earliest evidence of tuberculosis consisted of pleural effusion which was detected in March 1945. The next important clinical finding was the hard non-tender epididymis first noted in October 1945, at which time severe headaches with associated fever had been present for 3 weeks.

Presumptive evidence indicated the right lung as the probable initial site of tuberculosis.

Intrathecal streptomycin each day and intramuscular streptomycin every 3 hours for 27 days, totaling 11 million units, was given without apparent toxic effect.

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President's Page

FINALE

This issue of the Medical Annals contains my last "President's Page." There are a number of different subjects that pass through my mind which I might write about, but the one that concerns me most is the prepaid medical plan which will come up for consideration in June.

I had felt confident that it would be adopted by the Society when it was first presented on the night of April 24. I think most of the members present that night were in favor of the plan, but as there was a smaller group that were against it, it was recommitted to the Committee on Medical Care for further study. Hearings were arranged so that anyone in the Society could offer suggestions which might improve the plan. Everyone seemed to see the wisdom of this postponement. Dr. Frank D. Costenbader, Chairman of the Committee, tells me that he feels real progress is being made to iron out the differences, and I hope everyone will feel satisfied enough to approve it and get it started when it again comes before the Society. Once launched and operating successfully, we can amend and broaden its scope. Personally, I think we will have one of the best prepaid medical plans in the country. It seems as I talk to different members of the Society that everyone is in favor of the idea of a voluntary prepaid plan, so if this is true let's all get behind it and see that this plan is approved.

As retiring President, I again want to thank the Society and all the different committees for their loyalty and friendship. I want to thank the Executive Board and the Woman's Auxiliary for their fine work. Not only do I extend to Dr. Oscar Hunter my personal appreciation for the wonderful programs he has given us, but as spokesman for the entire Society I extend their sincere thanks. Certainly we have had splendid and appreciative audiences for our speakers. I want to thank our efficient and enthusiastic Secretary, Theodore Wiprud, for the help he has given me. Finally, I want to extend to Dr. William P. Herbst, Jr., our incoming President, my wishes for a most successful and enjoyable year.

Wm. Earl Clark

Editorials

TRIBUTE TO A PATRIOTIC SERVICE*

As physicians and dentists who served with the armed forces are rapidly returning to private and other civilian practice, it seems appropriate to recall here their splendid response to the Nation's need during the dark days of the war. On May 17, the Directing Board of the Procurement and Assignment Service held its final meeting, and on June 30, the Federal administrative office will close its books. The history of that Service is a lasting tribute to the unselfish spirit of loyalty and sacrifice throughout the medical, dental and nursing professions.

Five years ago, with war still only a dark cloud on the horizon, the Surgeon General of the Army asked the American Medical Association for assistance in meeting the medical needs of a rapidly growing Army, and the Association immediately appointed a committee to study the problem. The need for more physicians also by the Navy, the U. S. Public Health Service, and an expanding industry soon became evident. Similarly it was evident that such needs must be met without interfering with adequate care for the civilian population or the operation of hospitals and medical schools.

On the basis of the committee's studies and recommendations, there was set up the Procurement and Assignment Service for Physicians, Dentists, Veterinarians, Sanitary Engineers and Nurses which was later placed in the War Manpower Commission and finally in the Federal Security Agency. The operation of this Service represents one of the outstanding examples of achievement through voluntary coöperative effort during the war emergency.

The first problem of the Service was to establish a roster of physicians, dentists and nurses, including information concerning their professional, physical and dependency status. This was made possible through the coöperation of the professional organizations and individuals within the professions. It should be emphasized that all of this was voluntary on the part of members of the professions—an indication of willingness to serve where they could serve best.

Under the chairmanship of Dr. Frank H. Lahey, of Boston, a Directing Board was established consisting of four physicians, a dentist, a sanitary engineer, and two nurses. As Chairman, Dr. Lahey performed outstanding service in the national interest. Happily, recognition was taken of his unselfish and untiring devotion to this cause when he was recently awarded the Medal for Merit by the President. The Directing Board, besides determining general policy, arranged agreements with the armed services and other Federal agencies concerning recruitment, and assisted in developing policies on medical training and a "9-9-9 Intern-Resident Program" designed to prevent depletion of hospital staffs.

A chairman was appointed in each state who was responsible to the Directing Board. The state chairmen in turn appointed county committees who were familiar with local conditions and could provide information on the need for and availability of physicians and dentists in their local communities. This voluntary organization which extended to every part of the country accumulated information on professional needs and resources never before approached.

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* This is the fifth in a series of guest editorials by distinguished physicians and laymen. Others to follow will deal with the scientific, social and economic aspects of medicine.

That is the machinery operated principally by members of the professions to supply services for the armed forces and protect the medical needs of civilians during the war years. Its accomplishments are worthy of the highest praise. By V-J Day in 1945, some 65,000 physicians had been made available to the Army, Navy and Public Health Service. The standards of medical service provided on the American fighting front were higher than had ever before been dreamed of. It is a matter of record, too, that general health among civilians remained remarkably good.

A review of the organization and accomplishments of the Procurement and Assignment Service can never give any real picture of the individual time, thought and energy which contributed to its success. State chairmen and local committees who carried out so many thankless tasks without remuneration will probably never receive full recognition for their services. Similarly, the contribution made by the professional organizations will never be generally realized.

Accounts of the war for years to come will bring to light many instances of heroic acts and services performed by members of the professions on the war front. But among the unsung heroes will be those who remained at home. There are the practitioners who, at risk to their own health, worked long hours to provide professional care for the civilian population. And there are those who, in addition to carrying on their own practice, devoted many hours to free service for the Government to make possible an equitable distribution of manpower in the medical, dental and nursing professions.

Watson B. Miller
Federal Security Administrator

COMMUNITY PLANNING NEEDED

The searching administrative study of health agencies and hospital facilities of the Washington Metropolitan Area (reported elsewhere in this issue) will give all physicians much food for thought.

While most urban areas have some deficiencies in such provision, a careful perusal of the findings in the report would suggest that the Washington area has abused the privilege.

Without observing here the detail of the report, it is evident that the distinguished surveyors from New Haven and New York were impressed by the general lack of coöperation and coördination between agencies and between different parts of the area. They felt (in speaking of hospitals) "that this community has been lethargic for years in meeting problems which other communities of equal or larger size meet much more effectively"; and later, "Just as this area seems backward in group consideration of hospital problems, so is it behind the times in providing itself with group services which could be of material advantage to the hospitals."

Dr. Claude W. Munger, in his oral summary of the hospital report, said on April 30, "Perhaps the foremost lack in hospitalization for this area is the complete absence of effective coördinated planning for the unified coverage of hospital needs."

Was it with such considerations in mind that, in speaking of the health field, Dr. C.-E. A. Winslow said, ". . . we believe that the [Health] Department would gain—both in efficiency and in prestige—if it had the counsel and backing of a properly constituted Public Health Council"?

Dr. Ira V. Hiscock put it this way in listing "weaker points": "inadequate functional and geographical coördination between the voluntary health agencies, and also between voluntary and official agencies, resulting in only limited joint planning and coöperative action."

This is a familiar pattern to those who have been long acquainted with the uncoördinated, isolationist efforts of individual hospitals and health agencies, both official and voluntary, in this area. It was for finding appropriate mechanisms in group planning that the Washington Metropolitan Health Council was organized. At the time this is written the Health Council had not yet analyzed the report made to it by its surveyors. The community looks to it to use its influence to put an end to the lack of community spirit which has become so obvious.

H. P. R.

NEW MEDICAL JOURNAL BY AND FOR WOMEN PHYSICIANS

Postwar expansion has brought a new professional monthly magazine into the field, *The Journal of the American Medical Women's Association*. This is the fulfillment of a long-standing dream on the part of the Association, to have as its official publication "a representative organ for reporting the best type of work by women in medicine and at the same time to offer an opportunity to all members of the medical profession to submit scientific articles for publication," to quote the editorial by Dr. Elise L'Esperance in the first issue. It also has a strong department of abstracts of books and articles and a running record of the Association and its activities.

This new journal succeeds *Women in Medicine*, a quarterly devoted to the general interests of medical women but which did not carry scientific articles.

The editor is Dr. Elise L'Esperance of New York, well known for her work in pathology and for her interest in cancer prevention clinics. She founded the Strang Memorial Clinic at the New York Infirmary for Women and Children in 1937, and later two clinics at Memorial Hospital. Dr. Alice Woolley, a friend of many of us in Washington, where she interned at Gallinger and Children's Hospitals, is Associate Editor. A full-time business manager, Mrs. Frances Mercer, of Nashville, Tenn., is responsible for the excellent technical quality of the magazine. The Editorial Board of thirty-five members contains names of women distinguished in many fields, not only in this country but in Canada, England, Cuba and South America.

Because of the great interest of the editor in cancer, it was suitable to devote the first issue, which was published in April, "Cancer Month," to that subject, with particular emphasis on the efforts being made clinically to detect and prevent cancer.

The introductory article is by Dr. Catharine Macfarlane of Philadelphia. If "the proper study of mankind is man," then why not "the proper study of cancer in women is woman"? This idea, so simple it did not seem scientific, so unexciting because it meant the routine examination of well people, was put into effect by Dr. Macfarlane and her colleagues in 1938 when they started the semi-annual examination of 1,000 Philadelphia women. This was continued for five years. As a result of Dr. Macfarlane's enthusiasm and her findings that many cancerous and precancerous conditions exist in apparently healthy women, a number of cancer clinics for women have been started over the country. Now there are even clinics for men. The details of the Cancer Prevention Clinic at the Women and Children's Hospital in Chicago are presented by Dr. Augusta Webster and her colleagues. Other phases of cancer study are given by Dr. Edith Quimby of New York, Dr. Faith Fetterman of Philadelphia, and Lucy R. Milligan, National Commander, Field Army of the American Cancer Society.

There is a College Section and the usual news items; the work of the Association itself is reported by two of its important committees, The American Women's Hospitals and the Committee on Organization and Membership. Plans for a preconvention meeting in Los Angeles and the convention in June at San Francisco are included.

The format is attractive; the printing and plan of make-up show high professional skill. The black and white title against the contrasting light grey of the cover is distinctive.

As a member of the American Medical Women's Association, I am proud to introduce to my Washington colleagues this publication of our Association.

ELIZABETH KITTREDGE, M.D.
Member of the Editorial Board,
The Journal of the American Medical
Women's Association

In and Out of Focus

BY THE OBSERVER

Lull for West

The recent retirement of Dr. Olin West as Secretary and General Manager of the American Medical Association was not unexpected. However, it was thought that he would carry on at least until the forthcoming meeting of the AMA in San Francisco. But it appears that, for reasons best known to himself, he decided it was time he terminated his long service with the Association.

American medicine is deeply indebted to Dr. West, for he was an able, courageous leader. Often stubborn and unyielding in his views, he never flinched in the face of opposition. It was not in him to compromise where his convictions were concerned. To him is due in a large measure the credit for the AMA's strength as an organization, for he was ever a jealous guardian of its welfare. His thorough honesty and sincerity could never be questioned. There is no doubt that his name will always be remembered by the medical profession with gratitude and affection.

As it does to all men, the time had come for Dr. West to step aside and he did so with the dignity to be expected of him. His place has now been taken by Dr. George F. Lull, former Deputy Surgeon General of the United States Army. Those of us who live in Washington know Dr. Lull well. To us he is still "General" or, better still, "George," one of the best loved military figures in the Nation's Capital.

It can be said without reservation that in the opinion of the Washington medical profession, the AMA is extremely fortunate in obtaining the services of Dr. Lull. His outstanding qualities are courage, forthrightness, and undoubted ability. He is a natural leader and a clear, forceful speaker. Doctors will find him approachable and good-natured. A rather large man, he is the fortunate possessor of an unusually fine physique which will stand him in good stead in his new position.

Some objection has been raised to the fact that he has not been in private practice. It is true, of course, that he was a regular Army man. However, he has long been interested in the problems of private practitioners and has demonstrated his sympathy for the civilian doctors' point of view. His outlook on today's medical scene is realistic. He certainly is not doing any wishful thinking.

It is quite apparent to those who have any knowledge of the problems confronting the AMA that Dr. Lull's burdens will be heavy indeed. He is big enough in every sense to carry them, which is extremely important.

Dr. Lull's appointment as Secretary of the AMA must, of course, be confirmed by the House of Delegates in July. There is no doubt that he will receive the support he needs. However, it is to be hoped that the vote will be unanimous so that he can go forward in the full confidence that back of him is a united medical profession.

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"...Workers in the Same Vineyard..."

In talking to internists, one often senses the feeling that proper recognition has not been given their specialty, especially when it is compared to surgery. This schism, if it can be called that, is to some degree economic, because there is considerable disparity between the compensation of internists and surgeons. The former resent the fact that even in a long and serious illness they are not paid what the surgeon receives for an operation which, including after-care, requires a fraction of the time.

But differences between physicians engaged in these specialties go deeper than that. This is emphasized by Dr. Thomas Findley, Assistant Professor of Clinical Medicine, Tulane University School of Medicine.*

"An internist has been defined as a man who is totally unable to answer either yes or no to any question," Dr. Findley writes. "The definition was made in jest but there is much truth to it. If there is such a thing as a typical internist, he is a sedentary individual, curious, skeptical, reflective. He is accustomed to look at the patient as a unit rather than as a collection of separate organs and, if he has had the fundamental scientific training he should have had, he is eager to distinguish between a fact and someone's opinion. Although often powerless to suggest an alternative procedure, he regards every operation as an exercise in violent therapeutics and a confession of failure to cure. He is, however, humble before the complexities of modern surgical technique. His fees are not such as to command general admiration.

"The surgeon, on the other hand, is a man of action. He lives in an exhilarating world of knives, blood, and groans. His tempo is of necessity rapid. He is inclined to look at his less kinetic colleague with an air of puzzled condescension but may, in a relaxed moment, admit that the medical man is occasionally able to assist uncomfortable dowagers in the selection of a cathartic. Accustomed to legerdemain and quick results, he is apt to regard the diagnosis and treatment of a headache, for example, as a trivial matter, forgetting that the internist may require hours of probing before discovering that what the patient needs is not a new pair of glasses but a different mother-in-law. The surgeon and the internist are workers in the same vineyard, but their points of view are inevitably different."

Dr. Findley then describes the exasperation of the internist when he is confronted with the patient whom he finds, under close scrutiny, has no organic ailment.

"The standard reaction on the part of the medical attendant then is that of anger," he says. "The patient is automatically regarded as an impostor who has no right to his symptoms and his visit to the clinic is looked upon as a nuisance and an intrusion."

But these patients demand action. They want something done to them regardless of consequences to alleviate their discomfort.

"And so these people," Dr. Findley continues, "come to us in their distress demanding both action and relief. This demand comes not only from the patient but from the family as well. One can never enter a sickroom without being immediately aware of immense forces at work. The urge to violence is often so compelling that it requires great courage to follow the wiser course and do nothing. Certainly it is a commonplace experience for patients to complain that we have found nothing for which to operate upon them, and it is no consolation to these people to be told that their roentgenograms and blood tests are negative. It is another curious fact that no one minds being told that he has something wrong with one or more of his organs, but he bitterly resents the implication that the trouble lies within himself. A heart that is failing a little, a sluggish liver, a pair of weak lungs—these are cherished and respected ailments—but a personality defect is accepted with the greatest reluctance.

"In dealing, as it must, with individuals whose primary difficulty is emotional, a clinic finds itself in a peculiarly dangerous situation because a certain percentage of these patients will inevitably present some physical abnormality which, in a more stable host, would be a legitimate surgical target. The diagnosis of anxiety state, chronic reactive depression, or conversion hysteria is not made by exclusion, however, and it would be a major error to assume that an elderly housewife could not have a psychogenic backache and a fibroid tumor as well. The surgeon often accuses the internist of complacency and ignorance when he chooses to ignore a uterus which is not quite perpendicular, or a solitary gallstone, or a pair of tonsils from which a fluid of unknown composition can be expressed. There are certain people, however, who demand violence; the surgeon enjoys removing organs and one function of the internist is to see that these two never meet."

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* Originally published in *Surgery,* October 1944. Reprinted in the *Rhode Island Medical Journal,* February 1946.

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Private Group Clinics

There have been indications in recent months of a growing interest among physicians, particularly younger practitioners, in group practice. It will be recalled that during the war the American Medical Association canvassed physicians serving with the armed forces to ascertain their plans for the postwar period. A majority of the younger medical officers indicated their desire to enter a group practice. The reaction of Washington physicians in the services was about the same as the Nation as a whole. Your Observer communicated regularly with nearly all medical officers from the District and on one occasion at least he made direct inquiry as to their views. The response of those who replied was nearly unanimously favorable to the group method of practicing medicine.

For the benefit of physicians who are still a little vague on the subject, the question might be asked: "What is group practice?" Dr. Franz Goldmann, Associate Clinical Professor of Public Health, Yale University, gives this definition in the April number of the *Connecticut State Medical Journal.*

"Group practice may be defined as a system of cooperative practice of medicine by physicians for the purpose of pooling experience and skill, facilities and equipment, technical and other auxiliary personnel, and operating expenses if not also earnings. It aims at the improvement of quality, quantity, and effectiveness of medical care, the reduction of its costs, and the decommercialization of the practice of medicine. It constitutes an attempt to adjust medical practice to the rapid scientific progress and the profound socio-economic changes that have taken place since the nineteenth century."

It appears that Dr. Goldmann has made a rather exhaustive study of group practice. In an article, "Potentialities of Group Practice of Medicine,"* he devotes considerable attention to private group clinics. Believing that what he has to say on this subject is of particular interest to many readers of this column, your Observer quotes extensively from Dr. Goldmann's article.

"To establish a group, initiative and leadership are essential. Highly skilled physicians, known for their integrity and sincerity, are certain to attract competent associates; and if they can resist the temptation to become autocrats they are likely not only to hold the initial group together but to stimulate and guide its further growth."

"In addition to leadership and character of the man who takes the initiative there is another prerequisite for the successful work of a group. The group must be congenial, and each member must be intellectually desirous and temperamentally capable of making a small sacrifice so the group as a whole can flourish. No illusions should be entertained about the difficulty of forming and maintaining a group of such physicians. By background and professional education the doctor is highly individualistic. Once he has received his degree and satisfied the requirements concerning the practice of his profession he lives in the constant fear that somebody may deprive him of his right to practice as he pleases within the limits of medical ethics. Some of those whose talents were but little utilized by the Armed Services and those who happened to have had unfortunate experiences when working in hospitals and outpatient departments will have to be convinced that private group practice is different—different in what it can give to the members of the group and what it expects from them. In the final analysis, all depends on the conviction of the staff that discipline of free men is what counts first, last, and most.

"Physicians genuinely interested in going into group practice have two possibilities to consider. They may join existing units or set up new organizations of their own.

"All available evidence indicates a considerable demand for specialists on the part of group practice units whose staffs were depleted during the war years. Quite a few private group clinics are planning to enlarge their staffs beyond the prewar size and to add general practitioners as well as certain specialists. However, the total number of openings in well organized group practice units may be expected to be too small to meet the demand from the younger generation of doctors.

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* Connecticut M. J., 1946, 10, 289.

'Under these circumstances it should not come as a surprise that a growing number of physicians, in particular many of those discharged from the Armed Services, are thinking of forming new group practice units. Such a venture requires careful preparation and consideration of many details, such as the feasibility of a unit in various types of communities, large and small, industrial and non-industrial; the total number of physicians and the composition of the staff; the financing of the physical facilities and the initial equipment; the method of organizing the payment for the services rendered by the group; and the method of distributing the income between the staff members.

"If experience and skill are to be pooled effectively the size and composition of the staff of a group practice unit must be such as to hold promise for the achievement of the desired end.

"At present some of the units consist of only three or four physicians; some have staffs of sixty to eighty professional persons, including physicians, dentists, pharmacists, and related personnel. Groups of ten to twelve physicians, in some instances complemented by dentists and pharmacists, are not uncommon in private group practice, and this fact may have a deep meaning. Obviously, a team of a few physicians, important as its work may be to a small community, will have to be satisfied with offering a limited scope of service. A very large group, on the other hand, can easily furnish complete service by full specialists, partial specialists, and general practitioners but it must be subdivided and organized flexibly enough to avoid the danger of assembly-line medicine and ensuing mechanization and depersonalization of the service.

"The size of a group depends on both the size of the population in a given area and the purchasing power of the people to be served. Experience available at present justifies the belief that a group practice unit needs one full-time physician for about every thousand persons eligible for service, although this ratio is subject to variations depending not only upon the scope of the service offered but on the need and effective demand for medical care, preventive and curative. The problem is not so much to figure out how many physicians ought to be on the staff of a group practice unit deserving the name but to determine how many full specialists of various types, how many partial specialists, and how many general practitioners would be needed and could be supported by a certain population. Actually, general practitioners and partial specialists constitute the majority of the staffs of many private group clinics and specialists dominate in others. With decrease in the population and the size of the group practice unit the chances of adequately utilizing the time of full specialists are diminishing. In this connection one point deserves emphasis. In contrast to individual practice, group practice offers more scope for consultation and specialists' services as both patients and physicians find it convenient to obtain all needed services in one place, and this opportunity is greatly enhanced in clinics which have made arrangements for a payment plan within the reach of the 'common man.' Experience has shown that in well organized group practice units more than one third of the clinic services rendered consists of specialists' services.

"It would be a grave mistake to place all emphasis on specialists' services in group practice units. The essential point is to organize the smooth coöperation of general practitioners and specialists and to enable the general practitioner as well as the specialist to realize their ideal posibilities, so the general practitioner can truly be the family doctor, the specialist can complement the general practitioner, and the patient can receive the optimum in quality, efficiency, and economy of service.

"Taking all sides of the problem into account one may say that a group practice unit should consist of at least six, if not ten, physicians. This would make it possible to include in the staff at least one surgeon, one diagnostician (internist) or pediatrician, and one specialist in ophthalmology, otology, and laryngology in addition to general practitioners each possessing some experience in a special field. In other words, group practice units are feasible in all but the smaller communities . . .

"The majority of the group practice units composed of private practitioners operate from clinics rather than hospitals. In some instances they own functional buildings, in others they have rented space in commercial buildings."

"Most of the private group clinics have well equipped X-ray and clinical laboratories, and some also other facilities, such as physical therapy divisions. Maintenance of these essential services does not pose much of a problem to a group of physicians because the operating costs are shared by all. As there is ample opportunity to utilize diagnostic and therapeutic services, the quality of medical care can be improved and the time- and money-consuming referring of patients to other doctors and institutions can be avoided. The possible inducement to 'make the equipment pay' can easily be eliminated by charging inclusive rates for professional and auxiliary services."

"By pooling technical and other auxiliary personnel.

> large group practice units can afford—and usually do employ—a business manager, accountant, and various types of clerical personnel as well as graduate nurses, laboratory technicians, and various aides. Addition of health educators and medical social workers is being contemplated by several groups. Units of medium size cannot help but be less ambitious. Usually they employ a business manager and clerical personnel in addition to some graduate nurses, nurses' aides, and laboratory assistants. The small units usually employ a secretary for administrative work, including finances, and a few nurses and technicians. Employment of various types of personnel with the resultant division of labor improves the service to the patient and relieves the physicians from consideration of financial questions as well as technical detail. In this respect group practice opens up possibilities not within the reach of most of the doctors practicing individually.
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> "Where does the money for the support of a private group clinic come from? At present the majority of such units make use of the itemized fee-for-service system, some charge flat rates, and some employ the prepayment method. Units which offer a plan under which certain services are rendered in return for regular prepayments often also accept patients who are not subscribers and charge them according to the amount of service rendered and on the basis of the usual schedule.
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> "There is no innate relationship between group practice of medicine and the methods of paying for professional service. As W. J. Mayo said: 'Properly considered, group medicine is not a financial arrangement, except for minor details, but a scientific coöperation for the welfare of the sick.' However, group practice of medicine will only gain in value if the savings it afford are passed on the 'consumer.' "

As might be expected, Dr. Goldmann, being very much the liberal, argues in favor of the prepayment method being used by private clinics. However, he recognizes that "the combination of group practice and group prepayment is a bone of contention," citing the Group Health case. He admits that the majority of clinics are operating on a fee-for-service basis.

As to the division of income among physicians participating in a group, he says:

> "In distributing their income, the private group clinics employ a variety of methods. Many allot fixed salaries to the staff members, with specialists and older staff members receiving more than general practitioners and younger colleagues. Some determine the compensation in proportion to the 'amount of business' brought in, while others use experience and skill as a yardstick. Some units have all staff members share in the profits—and if necessary in the losses—according to widely varying schedules. Others do not follow such policy. As a general rule, provision is made for continuation of pay during sickness, vacation period, and leave of absence for postgraduate work. In a number of instances, retirement benefits and other advantages are made available."

Dr. Goldmann is well aware that many private clinics have foundered because of differences over the division of income. Your Observer, as business manager of a small private clinic, learned too that this was the cause of dissolution of a number of such groups. Care should therefore be exercised in establishing a clinic that the arrangements in so far as the division of income is concerned is equitable and fair to all concerned and, most important, that the participants are thoroughly satisfied with the agreement entered into.

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"...There Is an Obligation..."

Few public officials have impressed your Observer as having greater ability than Senator Wayne Morse of Oregon. Whatever one may think of his views, there is no denying that he has an incisive, well trained mind and that he expresses himself most effectively.

Your Observer was present during the testimony given by William Green, President of the American Federation of Labor, before the Senate Committee on Education and Labor. This happened to be one of the few sessions of the Committee attended by Senator Morse. His statements on this occasion were so challenging and important to medical men that your Observer felt they should be brought to the attention of his readers.

Addressing himself to Mr. Green, Senator Morse said:

> "Would you agree with me that there is an obligation on the part of the medical profession to come forward

with a program that will remove from the workers of this country the fear of bankruptcy through illness and still protect our private property economy to the maximum degree possible—to come forward with a plan that will remove that fear and still give to the American medical profession this so-called private property economy that they claim is weakened to a degree under this proposal that you have testified in support of here? I am not saying that it would or would not be. Do you agree that there is an obligation on that profession to demonstrate and come forward with a plan that removes that fear that is hovering over every roof in the land?"

Of course Mr. Green replied in the affirmative. A little later Senator Morse concluded his remarks with the following statement:

"I think the medical profession is entitled to protection in the private property economy, but it has an obligation too in that it can best preserve that form of economy for the country as a whole if it will rise to its obligation to see to it that this fear of insecurity growing out of the failure of the great masses to have medical care, which is one of the great dangers to the preservation of private property economy, is done away with.

"And the medical profession needs to keep in mind always that whenever a large segment of our people see others in a better economic position who have benefits growing out of the private property economy that these others do not enjoy, they then form the ranks of the opposing army. I would put it this way: When you have a large segment or army of people who have little to lose in a change to state socialism, you encourage development of state socialism. That is why I have yet to be convinced of the merits of all the features of the so-called Wagner-Murray-Dingell legislation, but I have said at medical meetings, and I say here now, that I think the medical profession has got to go much further than it has gone yet to see to it that adequate medical care is given the masses of our people, large segments of which do not get it now. It is a great citizenship service they can perform if they really want the profession to operate under a private property economy.

". . . Just as sure as we are sitting here—and there is no sense in kidding ourselves about it, and the doctors had better recognize it—just as sure as we are sitting here, the next decade is going to see a demand from the majority of the people of this country for greater attention on the part of our Government to the health of the people of this country; and friends of the medical profession in the Congress of the United States, in my judgment, are going to be driven from the Congress if they take the position that no legislation at all shall be passed to improve the health of the Nation."

* * *

What Ails Us?

Even the most pessimistic soul would have hesitated to predict the turn of events since the end of World War II. It would have seemed inconceivable that we would be in such a sad state following one of the greatest military victories in history. For the fact is that one year after victory we are harassed by domestic storms, embroiled in international disagreements, and trying desperately to stave off another war. The road to a peaceful world is still a long and treacherous one.

Pertinent to these observations is a thoughtful treatise entitled "Rationality and Emotionalism" appearing in the April number of *School Science and Mathematics* in which Dr. John Benjamin Nichols, long an eminent Washington physician and a former President of the Medical Society, compares scientific advancement with progress in "the human, social, political, and economic fields of life" to the disadvantage of the latter.

"Instead," Dr. Nichols writes, "there has been little effective social invention and engineering, and the result has been stagnation and lack of progress in these non-material aspects of life and society. There are great desiderata which through the ages man has sought to attain—freedom, equality, justice, humanitarianism, economic security, happiness, enlightenment. In the world of today, however, there is still social unrest, turmoil, frustration, violent political conflict, economic insecurity and want. Wars continue to recur at frequent intervals, constantly increasing in deadliness and devastation, and attended with montrous exhibitions of mass cruelty and atrocities on the part of supposed enlightened and civilized peoples. These facts show to how little an extent human aspirations for racial betterment and happiness have been realized, and what slight and inadequate social and civic progress has been achieved; even how little the race has really emerged from primitive savagery.

"Even so far back as 1780 the astute Benjamin Franklin sensed the contrast between material and social advances, and made this prophetic utterance:

" 'The Rapid Progress True Science now makes, occasions my regretting sometimes that I was born so soon. It is Impossible to imagine the Height to which may be carried, in a Thousand Years, the Power of Man over Matter. . . . O that Moral Science were in a fair way of improvement, that Men would cease to be Wolves to one another, and that Human Beings would at length learn what they now improperly call Humanity.' "

What ails us that this situation should exist? Dr. Nichols directs attention to two factors—rationality and emotionalism. "Rationality or reason is an exclusive function of the intellect," Dr. Nichols observes. "It consists in the acquisition and coördination of knowledge (or of beliefs), and the exercise of intelligence and good judgment, entirely apart and free from the disturbing and distorting influence of emotion.

"On the intellectual side of the mind we can differentiate two distinct methods by which beliefs are arrived at, which may be termed the speculative and the scientific methods.

"The speculative method, by deduction, introspection, and hypothesis, erects elaborate structures of belief or philosophy on slight foundations of fact. In this method the processes are essentially subjective, deductive, and *a priori*; the mind works from assumed cause to effect, from subjective thought into the objective world. This was the method of scholasticism. Great thinkers in all ages have thus formulated complete schemes covering whole departments of knowledge or the entire universe, and have taken such pride in these brilliant creations of their own intellects, and have regarded them as so complete and perfect, that observation of nature was regarded as superfluous and unnecessary.

"The scientific method works in the opposite direction from the speculative. It is objective, inductive, *a posteriori* in character. It begins with a study of external phenomena, and, exercising a healthy skepticism, from them as a basis works out general laws. Rigidly suppressing preconceived notions and bias, this method by painstaking observation and investigation collects an adequate mass of objective data as a prerequisite to generalization.

"The speculative approach to knowledge is illustrated by the attitude of the celebrated (and overestimated?) seventeenth-century physician, Thomas Sydenham. 'It is my nature to think where others read,' boasted he. But thinking is not the first element in scientific research. The scientific method was exemplified by John Hunter, a century later, in his advice to Jenner, when the latter began to ponder on the subject of vaccination against smallpox: 'Do not think; investigate!' "

"The history of medicine is one example of the comparative efficacy of the two methods of approaching knowledge. For thousands of years medicine was completely under the influence of speculative methods; and the sterility, stagnation, and inefficiency of medicine during that long period is a convincing proof of the futility of those methods. On the contrary, within the brief span of the past sesquicentury, solely by the employment of the scientific method, medicine has undergone a wonderful transformation and made stupendous advances. Other fields of thought have followed a parallel course."

What part, then, does emotion play in our lives? Dr. Nichols says it is apt to interfere with the intellect and have disturbing influences on our judgment.

"Now emotion is just as essential and important a factor in the operation of the mind as is the intellect. Emotion is the dynamic power and motive force that impels men to action and initiates and maintains human activities; while reason, or the intellect, is the guiding principle. . . ."

"But undisciplined emotion is apt to run wild and go out of control, thus interfering with the wise guidance of reason, and wrecking the machine. Ignorance and error, credulity, intolerance, prejudice and bias, excitement and passion, hatreds and loves, self-interest,—factors such as these disturb the intellectual processes and lead to falsity and error. . . ."

"Since humanity is motivated and activated through emotional factors, the course of society and history will be strongly influenced by the character and validity of the emotional elements. If the basic factors are correct and well founded, progress will result; if they are unsound and unwise, there will be stagnation or retrogression. Irrational and unruly emotionalism, false through firmly held notions, deeply planted prejudices, economic pressure, mob hysteria and passion, cannot produce substantial progress; yet these are dominant elements in human nature and exert a major influence on the course of human affairs, for good or bad. Without the corrective guidance of reason and wisdom the social machine goes into the ditch. The faulty and misleading emotional factors are so firmly implanted in human nature and are so discordant that the ability to achieve social betterment seems to be almost impossible and hopeless, and the difficulties insuperable; this in contrast with the amazing advances which the world, guided by unemotional rationality, is making in material things."

To what conclusion does Dr. Nichols come? He says:

> "... There can be no more important or fundamental aim in the educational scheme than the thorough inculcation of the scientific method and attitude of mind, the use of the objective approach to knowledge. This will implement the exercise of reason, intelligence, wisdom, good judgment in human affairs, and will produce the most efficient technics and methods for conducting the activities of life. With the exercise of rationality must be conjoined rigid control of emotional factors so as to eliminate the distorting and misleading influences which these can introduce. ... Thorough training in unemotional rationality, so that it becomes an instinctive habit of the mind, is imperative in superior education."

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Where Political Medicine Has Failed

The public must have been shocked by conditions existing in mental institutions as described by Albert Q. Maisel in a recent issue of *Life Magazine.* For the picture he drew was sordid indeed. Mr. Maisel is not a new hand at this sort of thing. It will be recalled that his investigation of the Veterans Administration had much to do with the "housecleaning" which subsequently took place.

Obviously Mr. Maisel selected the worst institutions as examples, although he sought to prove that most mental hospitals have not kept abreast of the times. He would undoubtedly admit there are notable exceptions, such as Washington's St. Elizabeths Hospital, but few institutions in this country even approximate its standards.

Dr. C. Charles Burlingame, Psychiatrist-in-Chief of the Neuro-Psychiatric Institute of the Hartford Retreat, in a report to his Board of Directors, charges "political medicine" with being responsible for the sad state of our mental institutions. Dr. Burlingame says:

> "Currently, there is a nation-wide debate on the question of political or socialized medicine versus free enterprise in American medicine. The champions of political medicine have a great deal of government support, but at long last, the American Medical Association has come forward with an affirmative program designed to solve some of the difficulties, instead of continuing in its original role of opposing proposed measures while offering nothing affirmative in their stead.
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> "In relation to the controversy, the field of psychiatry occupies a unique position. Psychiatry itself, which grew out of the jails and the poorhouses, can scarcely be said to have quite as respectable an ancestry as other branches of medicine, which have progressed under the aegis of free enterprise in American medicine. Without receipt of public sympathy and private philanthropy, 95 per cent of the practice of psychiatry has been State medicine for over a hundred years.
>
> "As a matter of fact, free enterprise might well question itself as to whether it has shirked its obligations by sloughing off the care of the mentally ill and allowing psychiatry to get into the present-day state of affairs through political medicine.
>
> "There have been some good things and some reasonably good state institutions, but if we take the country as a whole, it is safe to say that only a small fraction of present-day knowledge in psychiatry is made available to the greater percentage of the patients in the six hundred thousand hospital beds already dedicated to the mentally ill of America. In some parts of the country, these victims of political medicine are probably not even receiving good board and room, to say nothing of scientific treatment.
>
> "The lack of progress in this example of political medicine is appalling, and to compare the average care of the mentally ill in this country with any other part of the world does not eradicate the public disgrace of the over-all picture.
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> "The public should call for an up-to-date assay of results in psychiatry, and should think long and carefully before plunging headlong into anything that even resembles political handling of the other branches of medical care. Let the people demand first that the responsibility already assumed in psychiatry by State and political medicine be satisfactorily answered. Let the people demand that the ability of State medicine be demonstrated in its present responsibilities before going farther along the road toward political handling of medical care.
>
> "The research attack upon this greatest of all public health problems is pathetic. Support from public funds is a mere pittance compared with the research backing which has come to other fields in which free enterprise in American medicine obtains. During the war period, the already pitiful State efforts in the field of psychiatry shrivelled, leaving us in a position which compares most unfavorably with the psychiatric progress achieved up to twenty years ago by State medicine.

"If the proponents of political medicine are really in earnest about improving public health, and if they are truly worried about the high percentage of rejectees on the military induction lines, let them look consistently at the fact that more than half of all the hospital beds in America are occupied by the mentally ill, and let them remember that approximately a third of the medical military rejectees, as well as approximately a third of the medical military dischargees, were in the field of psychiatry.

"Why ask for new worlds to conquer, when the obligations already belonging to socialized medicine have been so scandalously neglected? Why ask for more when a concentration of all their efforts and resources in this one field which is already their own offers the greatest single opportunity to bring health to the greatest number?"

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Credit Seekers Beware! Before these lines appear, hearings held by the Senate Committee on Education and Labor on the Wagner-Murray-Dingell bill will have come to an end. It was obvious from the beginning that this legislation had little chance of passage. However, the hearings served their purpose by focusing public attention on controversial health issues. Undoubtedly proponents of the legislation won a few converts to their cause but there could not have been a great number.

In view of this situation, claims made by medical organizations whose representatives appeared before the Committee might well be examined closely. There is already evidence that some of the professional groups who opposed the Wagner-Murray-Dingell bill are preparing to claim credit for its defeat. Your Observer sat in on all of the hearings participated in by medical organizations not in favor of the bill. None of them, with the exception of the American Medical Association, did more than a fair job of it. Even the Association's representatives were not uniformly good. The star witness was Dr. L. S. Goin of Los Angeles, who does well at any time and on any occasion. He is, without a doubt, one of the most effective speakers in the medical profession.

Of course, your Observer is not so naive as to believe that the fate of legislation is decided at Committee hearings. There are always "behind the scenes" activities on both sides. Events, too, have much to do with deciding issues. For example, American domestic affairs have never been in a more turbulent state than they are at present. What the outcome will be remains to be seen. But of one thing we can be sure, our country is going to be different. Conditions under which we have lived will necessarily change. And we ourselves will see things differently.

So to those who seek credit for the defeat of the Wagner-Murray-Dingell bill, we offer this advice. The battle against a government-controlled system of medical care is only temporarily won. Beware lest you fall victims of your own conceit.

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Our Future Population As is well known, the population trend in this country took an upward swing during the War. The extent of this growth is revealed in the April issue of the *Statistical Bulletin* of the Metropolitan Life Insurance Company.

"The birth rates in the years 1941 to 1945," the *Bulletin* states, "were the highest in more than a decade; the number of children born in these five years exceeded the total for any comparable period in the history of the country." Surprisingly, the civilian death rate, despite the wartime conditions, reached a new low.

"As a result of these favorable developments, the excess of births over deaths in the years 1941 to 1945 amounted to 7,750,000 as compared with 5,200,000 in the preceding five-year period. It appears quite certain that, because of the marked upswing in the birth rate, when the 1950 Census is taken, the number of children under 15 years of age in our population will exceed the number in 1940 by an appreciable margin. This is in sharp contrast with the experience in the decade from 1930 to 1940, when the number of children under 15 decreased by 3,000,000. From all these indications, one might be led to believe that our population is headed for a rapid increase in the years to come."

But the outlook in this respect, according to the *Bulletin*, is not bright. The high birth rate which has prevailed during the War is, in its opinion, temporary. It is admitted that because of the high marriage rate and the demobilization of men from the armed forces, the birth rate will continue relatively high for another year or two. But thereafter it is believed that the rate will return to the prewar level.

In support of this view, it is pointed out that even in 1943 when the birth rate reached its highest point, "the rate of natural increase still was not up to that for 1920." Since 1943, the natural increase has dropped considerably.

> "If conditions of fertility and mortality prevailing in 1920 had continued unchanged, a cohort of 100 white girls born in that year would eventually produce 125 daughters and 157 granddaughters. In other words, the 'net reproduction rate' for white females in 1920 was 1.252. In subsequent years the rate dropped steadily, until in the middle 1930's it was under one—that is, below the maintenance level. The fertility and mortality prevailing in 1936 would eventually have led to a population decrease of 5 per cent a generation. By 1940 the net reproduction rate had risen to 1.024, which meant that the population then was little more than reproducing itself. In 1943 the rate was 1.235, and in 1945 it was 1.138.
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> "A false optimism may prevail regarding the size of our future population as a result of the fact that the observed rate of natural increase in the past four years has been in excess of 1 per cent per annum. It should be emphasized that this measure is a misleading index of the course of population growth. Our present population has a high proportion of women in the reproductive ages, a situation which is necessarily only temporary, and in time will pass. When allowance is made for this fact—by taking into account mortality rates and reproduction rates specific for age—we have the 'true' rate of natural increase, which is generally much below the observed rate."

The *Bulletin* observes that the United States is not the only nation confronted with a downward trend in population. In several of the European countries the situation is much more serious. Various methods have been adopted to encourage the formation and growth of families such as subsidies and other benefits.

These conclusions are undoubtedly correct; but looking upon the scene as an ordinary citizen, your Observer has been impressed by the growing congestion in all communities, rural and urban, which he has visited. Statisticians to the contrary, he would be much happier if there were fewer people.

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Propagandists All! For some unexplainable reason the word "propaganda" has come into disrepute. Its definition, "any organized or concerted group effort or movement to spread a particular doctrine or system of doctrines or principles," certainly does not justify the bad odor which surrounds this term. For we are all propagandists in the sense that we espouse causes and are more or less vocal in their behalf.

Taking advantage of public sentiment toward propaganda, Senator James E. Murray, presiding at the hearings recently held by the Senate Subcommittee on Education and Labor, made much of the fact that the medical profession through its organizations was engaged in various forms of publicity in an effort to defeat the Wagner-Murray-Dingell bill. He referred to this as "propaganda," insinuating that it was a reprehensible activity on the part of medical men. Of course this is all bosh. The fact is that the medical profession is competing with experts in Senator Murray and those who support his point of view. It appears that even the Administration itself is engaged in propagandizing on a nationwide scale its views on health. As a matter of fact, President Truman was most certainly engaged in propaganda when he advocated his conception of a national health program.

Let us be honest with each other. We are all propagandists. We endeavor by various means to win people to our points of view. There is certainly nothing wrong in that. Senator Murray and the doctors themselves might well be reminded of this fact. Let us frankly state that we are propagandizing for the things in which we believe.

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Useless Activity It is a pleasure to listen to Earl Godwin, the well-known Washington radio commentator, philosophize, as he often does on his daily news broadcast. His observations have a homely, salty flavor, and he frequently "hits the nail on the head."

On an evening not so long ago, Mr. Godwin cautioned his listeners to "slow down on useless activity." Too many people, he observed, are running hither and yon to no good purpose. Nothing Mr. Godwin has said could be more profitably taken to heart. Your Observer, as much as he would like to deny it, belongs to a considerable company of which this is true.

How often one hears a man or woman enumerate as a matter of pride the many organizations to which he belongs and the number of meetings he is required to attend. As if racing from place to place without respite is something to boast about. Your Observer was amused by these individuals until it came to him suddenly that he was one of them. For he recalled without too much effort how often he had told his friends how busy he had been with meetings and what-not. It seems that he, like the others, believed that if he was busy enough he was living life "to the hilt," which, of course, is a fallacy. The truth of the matter is that such living is often very superficial. Lack of time to savor life removes from existence many things which are most worth while.

Your Observer intends to take Mr. Godwin's advice to heart. At least his intentions are good; whether or not he succeeds is another matter. He cannot resist suggesting to Washington doctors that they take stock of their comings and goings. They should remember their coronaries when they try to keep up with the thirty or more medical societies in the District. The existence of all of them may be justified, but common sense would suggest physicians had better pick and choose. For life lived on the run can at its best only lead to a most unsatisfying existence and at its worst, to disaster. In view of the demands made upon them, physicians, of all people, should avoid "useless activity."

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Footnotes Acting upon instruction of the Society at a special business meeting on April 24, the Committee on Medical Care has been holding hearings for the purpose of giving members an opportunity to present their views on the prepayment medical plan proposed by the Committee. At the time this was written, only the first hearing had been held. Several others are scheduled. The plan will come before the Society again for a vote on June 19. . . . The 17th ANNUAL SCIENTIFIC ASSEMBLY is scheduled for September 30, October 1 and 2. All sessions will be held at the Statler Hotel. . . . The Gallup Poll appearing in *The Washington Post* on May 19 disclosed that only four in every ten persons polled had heard or read about the Wagner-Murray-Dingell bill. Opinion was almost evenly divided among those who had some views on this legislation, as to whether the Government should take over the job of administering the health insurance program. Seventeen per cent of those who had an opinion suggested voluntary insurance programs such as the Blue Cross hospitalization plan; 12 per cent proposed medical insurance under Social Security; 11 per cent suggested special grants for hospitals and clinics to care for the needy; 6 per cent proposed private or community charity; and 12 per cent gave miscellaneous suggestions. Sixteen per cent did not know what should be done and another 26 per cent did not think anything was necessary. It is obvious, as Mr. Gallup points out, that public opinion is "generally uncrystallized." . . . Upon the request of the Subcommittee on Mental Health, Congressman John L. McMillan, Chairman of

(Continued on page 308)

PROCEEDINGS OF THE ANNUAL BUSINESS MEETING

The Annual Business Meeting of the Medical Society of the District of Columbia was held on May 1. There were approximately 125 members of the Society present.

Annual "Reports of Officers and Boards and a Review of Committee Activities," copies of which had been mailed to the Society's members previous to the meeting, and the Current Report of the Executive Board were unanimously adopted.

Following the business meeting, Dr. Robert C. Cook, Deputy Medical Director of the Veterans Administration, addressed the members present on "Opportunities for Physicians in the Veterans Administration."

Annual Report of the Chairman of the Executive Board

In presenting his report, the Chairman called attention to the "dissatisfaction and controversy which are characteristic of a period of readjustment" such as the country is now passing through. He expressed the hope that this phase would soon come to an end so the Society can get under way with its " 'reconversion' program." There followed a résumé of the Executive Board's activities.

The Chairman concluded his report by calling attention to the present "drive to establish a Government system of medicine," stating: "We cannot deny that the efforts in this direction seem to be gaining momentum. Our course—if we wish to continue to be a free profession—is clear. We must meet the issues before us realistically and, most important, constructively."

Report of the Secretary

The Secretary opened his report by stating that the normal peacetime pursuits which he expected to resume after V-J Day did not materialize as rapidly as he had anticipated but that he hoped by the close of 1946 a more integrated postwar program would be well under way. A brief résumé of the report follows.

During the past year the Secretary attended 153 meetings and conferences. On numerous occasions he was the Society's official spokesman on boards and committees of civic and other organizations. The Council of Social Agencies and the Washington Metropolitan Health Council might be mentione specifically since he has taken a very active part i both. He also represented the Society at hearing before legislative committees and other bodies There have been a considerable number of suc meetings in view of the many pressing health problems now before Congress.

The Secretary reported the conclusion of his work with the District of Columbia Procurement and Assignment Service for Physicians as of March 31 1946, when the War Manpower Commission closed the office which had been maintained in the Society's building. He stated that Dr. Paul F. Dickens District Chairman of Procurement and Assignment for Physicians, and members of his Committee had been properly commended for the excellence of their work by the national officers of the Procurement and Assignment Service.

The membership figures for the past five years were presented. They reveal the Society's satisfactory growth.

	1942	*1943*	*1944*	*1945*	*1946*
Active	855	881	915	931	977
Life	60	64	63	70	76
Associate	211	212	204	214	217
Honorary	7	9	9	9	9
Total	1,133	1,166	1,191	1,224	1,279

Because of the wartime ban on nonessential travel, plans for the 17th Annual Scientific Assembly (1945) had to be abandoned. In the spring of 1946, however, the Secretary assisted the Committee on Postgraduate Education in presenting a Postgraduate Course in Diagnosis. He also rendered assistance to the Program Committee, which was responsible for scientific programs described as the best in many years.

The Secretary devoted more of his time to the problems of returning medical officers, especially those who were members of the Society, than to any other activity. He continued his regular newsletters to members in the services until February, 1946, when most members had returned home. He emphasized that the letters had not been discontinued but would be less frequent.

The Society's efforts in behalf of returning veterans were carried out under the direction of the Committee on Service Physicians. To this committee were appointed several returning service physicians, all members of the newly created organization, District of Columbia Physician-Veterans of World War II.

The Secretary familiarized returning physicians by letter and interview with regulations or laws relating to licensure, narcotic licenses, malpractice insurance and drivers' permits. The problem of obtaining office space for returning physicians has been difficult. The Secretary participated in conferences with owners of large office buildings and appeared before the Zoning Commission with other representatives of the Society in an effort to obtain a relaxation of the regulations to permit physicians to establish offices in residential areas.

Distributors of Ford and Plymouth automobiles in the District were called upon by the Secretary to give returning service physicians priority. A number of physicians obtained cars through such intercession.

Certain facilities of MEDICAL BUREAU were made available to veterans, formerly members of the Society, without cost.

Conferences were held with Major General Paul R. Hawley, Acting Chief Medical Director, and Colonel J. C. Harding of the Medical and Hospital Section, Veterans Administration, for the purpose of developing a fee schedule for the examination and treatment of veterans by private physicians.

The Secretary assisted the Committee on Medical Care in preparing the descriptive material forwarded to members preliminary to formal presentation of the prepayment medical plan. Together with the Chairman of the Committee, he attended national conferences at which prepayment plans were discussed.

The Secretary had continued his duties as Managing Editor of the MEDICAL ANNALS, being responsible for most of the nonscientific material appearing in the journal. On the recommendation of the Editor, Dr. Wallace M. Yater, the Editorial Board was enlarged to include representatives of several specialties. Appointed to the Board as Associate Editors were Drs. James N. Greear, Donald H. Stubbs, Joseph S. Wall and Charles Stanley White.

The Secretary was able to report that despite difficulties in operation, MEDICAL BUREAU completed its most successful year, the audit at the end of 1945 showing an excess of income over expenses in the amount of $492.63. A total of 400 subscribers was reported, 241 to Alternate Listing Service and 159 to Telephone Secretarial Service. There had been an increase of 91 subscribers during the past year.

As Group Treasurer of the Doctors Group for benefits under Group Hospitalization, Inc., the Secretary reported a total of 459 subscribers as of March 1, 1946. This group has shown a steady increase each year in the number of members participating.

As in previous years the Secretary lectured on the social and economic aspects of medicine to medical students of Georgetown University, where he is Professor of Medical Socioeconomics, and of Howard University. He also addressed one regional conference, participated in several national conferences, and engaged in a radio debate on compulsory health insurance.

The Secretary concluded his report by expressing his appreciation for the services of employees who had been with the Society for a number of years.

ELECTION OF OFFICERS

Since the Nominating Committee presented only one slate of nominees for office at the business meeting, March 6, and no nominations were made from the floor at that time, the number of votes cast on May 1 was unusually light. The following officers were elected for the year 1946–47:

President-elect: Dr. Raymond T. Holden
First Vice President: Dr. A. Clagett Gray
Second Vice President: Dr. Catherine W. Johnson
Member of Executive Board: Dr. William Earl Clark
Member of the Board of Censors: Dr. Walter Atkinson

Dr. William P. Herbst, Jr., the present President-elect, will assume office on July 1, 1946. Dr. Holden will become President on July 1, 1947.

REPORT OF THE BOARD OF CENSORS

Following V-J Day and the release of medical officers from the armed forces, the number of applicants increased rapidly, the Board reported, 88 applicants having been elected as compared with 52 last year.

Adoption of Amendment XII to the Society's Constitution and By-laws, providing for the election of applicants by the Executive Board for a probationary period of one year, has extended the Board's activities by two months. The Board registered no complaint on this score but expressed the belief that the change in election procedure was a great improvement.

At its April meeting the Board voted favorably on the proposal of the Executive Board to confer upon Dr. Leonard G. Rowntree, formerly Chief Medical Officer of the Selective Service System, Honorary membership in the Society.

CURRENT REPORT OF THE EXECUTIVE BOARD

There are always matters which cannot be included in the Annual Report of the Chairman of the Executive Board because it is prepared some weeks in advance of the Annual Business Meeting. These items have always been incorporated in a supplemental report so that affairs of the Society will be brought up to date at that meeting.

This year there are not many items to be presented in the supplemental report, but your Board believes they are important enough to warrant your attention. In fact, one item, as this report reveals, must have your approval.

You, of course, realize that the Board is not presenting to you many matters which it properly disposes of itself. There is much routine in conducting the Society's affairs about which the members know very little. As a matter of fact, there is no reason why they should be bothered with them. Nevertheless, it should be of interest to you that it is not the major problems which require so much of your officers' time as it is the considerable amount of detail incidental to the operation of an organization as large as ours.

Election of Member of Board of Trustees of Group Hospitalization, Inc.—In accordance with the By-laws of Group Hospitalization, Inc., the Medical Society of the District of Columbia elects one member to its Board of Trustees annually. This year the Society must elect a successor to one of the following members whose terms expire: Dr. F. X. McGovern, Charles D. Drayton, and A. G. Neal.

Due to ill health, Dr. McGovern is unable to serve. Your Board, therefore, unanimously recommends the election of Dr. James N. Greear, Jr.

As most of you know, Dr. Greear was elected President of the Society in 1944. About the time of his election he entered the armed forces. While stationed in this country he carried on as President at considerable personal inconvenience. Upon being ordered overseas he resigned, and the then First Vice President, Dr. William M. Ballinger, completed Dr. Greear's term.

Dr. Greear has always been actively interested in the Society, and it is the belief of your Board that he will be a very valuable member of the Board of Trustees of Group Hospitalization, Inc.

17th Annual Scientific Assembly.—Due to the wartime ban on transportation, the ANNUAL SCIENTIFIC ASSEMBLY was not held last year. It was the first time the ASSEMBLY had been cancelled. Throughout the war years (prior to 1945), it had been conducted most successfully, reaching its high attendance mark in 1943 when the registration was 2,111.

It had been expected that in 1946 plans for the ASSEMBLY would get under way early. However, the Committee on Arrangements ran into difficulties because the Mayflower Hotel was not able to provide the space formerly allotted to the ASSEMBLY. The particular difficulty was the fact that District authorities would no longer permit the use of the Promenade for exhibits. This was a serious blow to the Committee, which held off making other arrangements in the hope that some satisfactory plans could be worked out with the Mayflower management. About the middle of April it became apparent that the Mayflower was out of the question.

Plans for the ASSEMBLY were then discussed with the management of the Statler Hotel, who agreed to make space available at a considerably higher cost than the Mayflower. Despite the fact that the overhead will be twice what it was when the ASSEMBLY was last held, Dr. W. Ross Morris, General Chairman, decided to proceed with plans for the meeting provided the arrangements at the Statler met with the approval of the Executive Board. In spite of the costs involved, the Board approved the ASSEMBLY's being held at the Statler in the belief that the technical exhibitors would be willing to pay considerably more for the space allotted them.

As it stands now, the scientific sessions will be held in the very attractive Presidential Room; the Congressional Room will house some forty of the technical or commercial exhibitors; the scientific exhibit will be situated in the South American Room and the corridor leading to that room will be used for a War Souvenir Exhibit. Motion pictures will be shown in one of the parlors.

There is every prospect that this year's ASSEMBLY will be by far the most successful ever undertaken by the Society. It is hoped that all of our members will make plans now to be present during the three days the ASSEMBLY is to be held, September 30, October 1 and 2.

Publication of the History of the Medical Society of the District of Columbia.—As some of our members know, a history of the Medical Society, which has been in preparation for the last two years, was completed several months ago. The history covers the period 1909 to 1945, where the Society is concerned, and also records the history of the Medical Association of the District of Columbia, which was organized in 1833 and amalgamated with the District Medical Society in 1911.

It was a tremendous task to examine the minutes, letters, pamphlets, and other material to obtain the facts which have gone into the history. This was done by Dr. John B. Nichols, Chairman of the Committee on History, to whom is due the credit for the manuscript which recently went to the printers for bids. Other members of the Committee who reviewed and approved the work are Drs. William J. Mallory and Joseph S. Wall.

Within the next few weeks, members of the Society will receive an announcement of the publication of the history together with an order form. It is exceedingly important that the Society know how many members wish to buy copies. Orders should therefore be entered promptly.

Arrangements Made for Photographs of Members.—Most of you are familiar with the composite picture of the Society's membership which now hangs in the outer office. Most of the individual photographs in this picture were made in 1935, eleven years ago. Many changes have taken place during this period, due in no small measure to the war. There have, of course, been deaths, removals, and an influx of new practitioners.

One of the leading photographers of the city recently approached the Executive Board with the proposal that the membership again have individual photographs taken and that a composite picture similar to the one referred to above be made. Your Board was interested, as it believed this was a propitious time to have pictures taken, and therefore accepted a proposal made by one of four photographers interested—the Woltz Studio—which agreed to:

1. Photograph the membership and submit proofs to the individual doctors.
2. Furnish the Society with one glossy print from the negatives selected by the individual doctors without charge.
3. Make a composite picture so that the individual doctors may purchase it if they desire, and give the original of the composite picture, regardless of the number of sections, to the Society without cost. The original picture is also to be framed by the Studio gratis.
4. Not to pressure any doctor to buy photographs for his own use.

The taking of photographs will get under way within the next few weeks. We hope that you will lend your coöperation in this undertaking.

Mention might be made of the fact that your glossy print will be filed with the biographical data which most members furnished the Society recently. This would seem an opportune time to remind members who have not returned the large, yellow form on which to record biographical information about themselves that they should do so promptly, for it will have great value to the Society and perhaps later to the member's family.

Hearings on the Wagner-Murray-Dingell Bill.—It is to be regretted that not more Washington physicians have listened in on the hearings held by the Senate Committee on Education and Labor on the Wagner-Murray-Dingell bill. Had they done so, they would have a much better understanding of the implications of this legislation for the future of medicine. Hearings are still continuing, giving innumerable groups an opportunity to express themselves on national health legislation. Most witnesses are in favor of the bill proposed. Among them are representatives of labor, social service and professional organizations. Some medical groups, such as the Physicians' Forum, are also supporters of the bill. However, they are in the minority where doctors are concerned.

Among medical organizations appearing against the bill have been the American Medical Association, the National Physicians' Committee for the

Extension of Medical Service, and the Association of American Physicians and Surgeons. In the opinion of most observers, the representatives of the AMA made, on the whole, a good showing. Especially effective was Dr. Lowell S. Goin of Los Angeles, who was one of the best medical witnesses ever to appear before a Congressional committee on a health bill.

Perhaps the implications of the hearings to date can best be summed up as follows: There is a possibility of the Wagner-Murray-Dingell bill being reported out by the Committee; however, its passage this year is improbable.

There has not been much interest shown in the hearings by members of Senator Murray's Committee. Only one has been a regular attendant and he is Senator Forrest C. Donnell of Missouri, whose views are in accord with those of organized medicine. His questioning of the witnesses appearing for the bill has heartened many medical men who were present.

IN CONCLUSION: This, then, concludes the business which your Board has to present for the year 1945–46. Like all of you, members of the Board are looking forward to years of peace and prosperity and, it might be added, "normalcy."

Plans are in the making, the object of which is to make the Society a more effective instrument both in the interests of its members and the public. Your support for them in 1946–47 is solicited.

ANNUAL REPORT OF THE WOMAN'S AUXILIARY

The Woman's Auxiliary to the Medical Society of the District of Columbia has now been in existence for 20 years. It has approximately 300 members, 15 new members having been added during the year.

The Auxiliary has held a regular meeting and an Executive Board meeting each month from October through May; also a January tea and a spring luncheon.

To add interest and encourage good attendance, a guest speaker was invited for each regular meeting. We are all greatly indebted to Mrs. Edgar E. Quayle for the excellent programs we have had. The speakers and their subjects were:

W. M. Escavaille, Jr.: "Alcoholics Anonymous"

Lancelot Sukert: "The Gardens of Dumbarton Oaks"

Mrs. Georgette Ross Howard: "The Modern Deborahs"

Mrs. John Waters: "Holidays"

Captain Rhoda J. Milliken, head of the Women's Bureau of the Metropolitan Police: "Present-day Problems of Children in Washington"

Mme. Camille Chautemps, wife of the former Premier of France, presented a delightful musical program. Dr. William Earl Clark, President of the Medical Society of the District of Columbia, spoke at the final meeting.

Mrs. Richard Dunkley, Chairman of the House Committee, arranged attractive buffet luncheons which were served at the close of each meeting. These have fostered good fellowship among the members.

In February, under the able leadership of Mrs. Leo Brison Norris, Chairman of the Ways and Means Committee, the Auxiliary sponsored a play, "A Portrait of George Sand," a comedy drama by Betty Souby, which was given in the auditorium of the Arts Club in Washington. The main purpose of the project was to raise funds for redecorating the auditorium in the Medical Society's building.

The Auxiliary gave contributions to the Washington Community Chest, the District of Columbia Tuberculosis Association, the Washington Heart Association, and American Relief for France.

A very happy ending to the year was the luncheon which was held at the Mayflower Hotel at the close of the final meeting. A number of the charter members and several of the Past Presidents were honored guests.

The Officers elected for the coming year are: Mrs. William P. Herbst, *President*; Mrs. William J. B. Orr, *First Vice President*; Mrs. A. Barnes Hooe, *Second Vice President*; Mrs. Richard H. Todd, *Recording Secretary*; Mrs. Leo C. Varden, *Corresponding Secretary*; and Mrs. Harry S. Lewis, *Treasurer*.

The delegate to the national meeting in San Francisco in July will be Mrs. Oscar B. Hunter.

(*Continued on page 308*)

HEALTH AND HOSPITAL SURVEY COMPLETED

Many gaps and inadequacies in the health and hospital picture of the Washington Metropolitan Area are found in the report of the Board of Surveyors, working under the sponsorship of the Washington Metropolitan Health Council, which was released in May.

The first news of their findings appeared in the newspapers of May 1 following an oral summary given by the three principal surveyors at a joint meeting of the Health Council and the Council of Social Agencies, on April 30, at the Department of the Interior Auditorium. Remarks were made by Dr. Ernest S. Griffith, President of the Council of Social Agencies; Dr. Herbert P. Ramsey, Chairman of the Health Council; and Vice Admiral Ross T. McIntire, Chairman of the Survey Committee. Admiral McIntire introduced the surveyors, Dr. C.-E. A. Winslow, Dr. Ira V. Hiscock and Dr. Claude W. Munger.

The separate chapters of the final report were reviewed by the press day after day for several weeks. It was announced that the Survey Committee was studying the 475-page report prior to its own report to the Health Council. The Survey Committee is composed of the following members: Admiral McIntire, *Chairman*; Dr. Ramsey, *Vice Chairman*; Ramone S. Eaton, Alexandria; Mrs. Art Brown, Arlington County; Colonel Waldron E. Leonard, Fairfax County; Mrs. O'Neal Johnson, Montgomery County; Mrs. William Werber, Prince Georges County; and Miss Gertrude H. Bowling, Dr. Paul B. Cornely, George A. Garrett and Dr. Vane M. Hoge, Washington and general.

The survey was conducted under an appropriation of $24,000 by the Community War Fund.

While the report cannot be reviewed in detail in this issue of the MEDICAL ANNALS a few of the 160 recommendations can be listed:

1. The readjustment of the Health Council on a more effective area basis.
2. The organization of a metropolitan hospital council.
3. Legal provision for public health councils, advisory to health officers.
4. District of Columbia representation in Congress.
5. Passage of measures like the Tydings bill.
6. Decentralization of hospital admitting activities to the hospitals.
7. Reorganization of the District Bureau for Tuberculosis.
8. A Bureau of Hospitals in the D. C. Health Department.
9. Adequate budgets for official and voluntary health agencies.
10. Greater coördination and group planning through the health and hospital councils.
11. Greater provision for the needs of negro patients and negro medical education.

The following is a list of the 19 chapter titles:

I. Sanitation
II. Communicable Diseases
III. Tuberculosis
IV. Gonorrhea and Syphilis
V. Maternal and Child Health
VI. School Health
VII. Nutrition
VIII. Mental Hygiene
IX. Dental Care
X. Heart Disease and Cancer
XI. Public Health Nursing
XII. Health Education
XIII. Hospital Care
XIV. Outpatient Care
XV. Convalescent Care
XVI. Care of the Chronically Ill
XVII. Review of Official Health Agencies
XVIII. Review of Voluntary Health Agencies
XIX. General Review of Facilities for the Care of Illness.

DISTRICT STUDY OF CHILD HEALTH SERVICES UNDER WAY

Progress of the Study of Child Health Services in the District of Columbia is keeping pace with the majority of states throughout the Nation. Distribution of questionnaires is well under way and prompt return of accurate and completely filled forms will greatly reduce the time required for completion of this tremendous undertaking.

Inasmuch as this is to be a complete study of all health services for children, all individuals contributing to these services share responsibility in the conduct of the Study. Only a small proportion of all medical care given to children is accounted for in the services of physicians who limit their practice to pediatrics. The general practitioner carries the major part of the burden of this care. Therefore the full coöperation of the physician in general practice is essential to the ultimate success of this Study.

The Medical Society of the District of Columbia, having endorsed the purpose and objective of the Study of Child Health Services, is represented on the committee serving in an advisory capacity to the conduct of the Study, together with representatives of hospital and community health organizations.

When the Study is completed in the District of Columbia the data will be tabulated, with that of other states, in the Central Office of the Study of Child Health Services. The results will be made available to the states in tabular form and the information will be used to stimulate local planning for better medical care.

Prompt and accurate attention in furnishing data requested on questionnaires will make it possible to hasten the availability of pertinent facts for use in making well-founded plans for the future medical care of children.

THE USE OF GAMMA GLOBULIN IN MEASLES OUTBREAKS

A marked increase in the incidence of measles during the early months of 1946 caused the Health Officer of the District of Columbia to invite representatives of the United States Public Health Service, the Medical Society of the District of Columbia, and the Medico-Chirurgical Society, Inc., to meet with members of the District Health Department for the purpose of formulating recommendations as to the best possible use of gamma globulin in measles outbreaks. Physicians representing the above organizations were Dr. Milton Veldee, Dr. William F. O'Donnell, and Dr. Roland Scott. The following procedures were recommended:

General Policy: Gamma globulin will protect against measles for a period of but 3 weeks. It should be used primarily for infants under 2 years of age and in older children when medically indicated. Globulin should be administered only after definitely known household exposure to measles.

A limited supply of gamma globulin has been furnished free to the Health Department by the American Red Cross. Physicians may obtain the globulin without charge for the treatment of appropriate cases by applying to the Health Department's Bureau of Preventable Diseases, New Municipal Building, 300 Indiana Avenue, N.W.

Children under Two Years of Age: In all children under 2 years of age who have been exposed and in children chronically or acutely ill, exposed to measles, it is recommended that gamma globulin be administered in preventive doses. *Dosage:* 1 c.c. per 10 pounds of body weight.

Children Two to Six Years: In normal healthy children from 2 to 6 years of age who have been exposed to measles modifying doses of immune globulin may be given. *Dosage:* 0.25 c.c. per 10 pounds of body weight.

Children Six Years and Older: Gamma globulin is not recommended except in debilitated children.

Reaction to Gamma Globulin: There is usually no reaction. Globulin should never be given intravenously.

Time for Administration: Optimum time is 4 to 6 days after exposure.

Duration of Protection from Gamma Globulin: 2 to 3 weeks.

Is gamma globulin effective in German measles? No. Measles and German measles are two separate diseases.

Is gamma globulin used for the treatment of measles in the active stage? No, it is used only for the prevention and modification of measles but not after the disease develops.

CALENDAR OF MEETINGS

May 1	Annual Business Meeting of Society
May 3	Program Committee
May 8	Scientific Meeting of Society
May 10	Committee on Medical Care for Veterans
May 15	Committee on Arrangements, Annual Scientific Assembly
May 17	Committee on Medical Care (hearings on prepayment plan)
May 27	Executive Board
May 29	Committee on Medical Care (hearings on prepayment plan)

THE RELATION OF ORGANIZED MEDICINE TO THE HEALTH DEPARTMENT IN TUBERCULOSIS CONTROL*

A. Barklie Coulter, M.D.

Director, Bureau for Tuberculosis, District Health Department

In discussing the relation of organized medicine to the Health Department in tuberculosis control, one must of necessity review many phases of the subject that have been worn nearly threadbare by repetition. Yet a clear understanding of this relationship is necessary if we are ever to eradicate what we know to be a preventable disease.

By law the control of tuberculosis is placed in the Bureau for Tuberculosis in the Health Department, but it is needless to say that without the help of the practicing physician, the Medical Society, the Tuberculosis Association, and other agencies interested in the field, such as the United States Public Health Service, the Health Department of itself could accomplish but little. Little progress can be made unless the physician, on the one hand, understands the aims and objectives of the official control agency, and the official agency, on the other, understands the problems of the physician. The aims of both the Health Department and the private physician are the same, the control and eventual eradication of tuberculosis. But the means employed by each differ greatly.

It is the responsibility of the Health Department to employ all means in its power to find the undetected case of tuberculosis. This not only means making roentgenograms of those persons who come to its clinics voluntarily but, more important, going out into the community to seek out cases where they are apt to be found. This type of procedure by the private physician would be considered unethical, in spite of the fact that he is striving toward the same end.

Tonight, I would like very briefly to sketch the function of the Bureau for Tuberculosis, with all its shortcomings, and to try to show how the work of the private physician can be best integrated in a tuberculosis control program.

Not only in the medical field, but in all other fields dealing with the organization for human betterment, there seems to be a lack of knowledge on the part of not only the physician, but also the public, of facilities at their disposal. One of the physicians that is now employed by the Bureau stated to me that he did not know there was a Chest Clinic in the District of Columbia until he became an attending physician.

At present the Health Department operates four Chest Clinics in the diagnosing of tuberculosis, the Southwest Health Center at Delaware Avenue and I Streets, S.W., the Polk Health Center at Seventh and P Streets, N.W., the Chest Clinic at 469 C Street, N.W., and the Freedmen's Chest Clinic connected with Freedmen's Hospital tuberculosis annex.

All persons who reside or work in the District of Columbia can be referred to these clinics. A person with tuberculosis living in Virginia or Maryland and working in the District of Columbia is as much a menace to the health of citizens of the District as another person with tuberculosis living in the District but who works in Maryland or Virginia. It is the desire of the Health Department that these Chest Clinics should be utilized by all physicians by referring their patients to them in order to rule out tuberculosis. Yet we find that in 1945, of 11,420 new cases admitted, only 1,254 or approximately 10 per cent were referred by the medical profession.

To look at it in another way, with approximately 1,900 physicians in the District there was less than 1 case per physician referred for examination. Whose fault is this? I admit that I have been somewhat negligent in bringing to the attention of the Medical Society, through the Medical Annals, the facilities for the control of tuberculosis. But I am sure that not only you but also the recalcitrant patient knows that there is a Bureau for the Control of Tuberculosis.

Many physicians are reticent in requesting that a patient's chest be X-rayed unless there are definite underlying signs or symptoms of disease. So long as this attitude predominates, cases will not be discovered until they are at least moderately or far advanced and cure problematical. It might be well to mention that among 32,400 Selective Service roentgenograms made by the Bureau for Tuberculosis, 333 cases were found, which is approximately 1 per cent. Few of these persons had any previous knowledge of symptoms of any pulmonary condition. These cases were found in apparently healthy individuals. How much more productive it would be to make X-ray films of all persons seeking medical aid, either in private offices or hospital clinics.

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* Read before the Society, February 13, 1946.

It has been stated that if tuberculosis is to be controlled in any locality at least 20 per cent of the population must be X-rayed each year. This means that we should strive to make films of some 200,000 persons in the District annually.

The Bureau for Tuberculosis has been greatly aided by the program of mass X-raying sponsored by the District Tuberculosis Association with some 18,000 films made in 1945. The United States Public Health Service in its preëmployment examinations studied approximately 57,000 persons. The Health Department, through routine admissions to the Clinic, applicants for the school system, and food-handlers, examined 23,000 persons. Even adding to this total all the roentgenograms taken by private laboratories and physicians in their offices, we still fall far short of the quota. To accomplish this will require individual effort on the part of the practicing physician and closer coöperation in the utilization of Health Department facilities by the various hospital clinics.

Once an active case of tuberculosis is discovered, the physician is often at a loss as to what procedure to follow in order to hospitalize a patient. In order to create a unity of procedure and to best evaluate the case in the order of urgency, physicians are requested that all cases requiring hospitalization be referred to the Clinic at 469 C Street, N.W. The patient should be given a referral from the physician recommending hospitalization and if possible a sputum and X-ray report, or better still the film itself.

The patient is then interviewed by the liaison nurse as to probable contacts or the suspected source of the disease and is given a referral slip to present to the Hospital Permit Bureau for admission to the Sanatorium. Once his residence is established, the Bureau for Tuberculosis is responsible for notifying the patient when a bed is available.

This brings us to the tuberculosis bed situation as it now exists in the District of Columbia. There are 1,177 beds for tuberculous patients. At the present time, unfortunately, due to lack of personnel, 311 of these beds are closed. Closed beds are reflected in the long waiting list, which at the moment total some 173 patients. For example, there are 40 white females awaiting hospitalization, and of this number 18 are considered urgently in need of hospital care.

A great deal of embarrassment has been caused in the past months by private physicians not having knowledge of this acute bed situation, stressing immediate hospitalization, and contacting the Sanatorium directly for the admission of their patients. The procedure I have outlined should be followed except in emergency cases which are admitted to Gallinger Hospital after the clinics are closed.

You can rest assured that the Bureau for Tuberculosis will do all in its power to see that all patients are hospitalized as soon as possible. Dr. Ruhland is exercising every effort to see that these closed beds are opened at the earliest possible date.

Let us review for a moment the control of tuberculosis as it can be helped or hindered by physicians. This phase of the subject can be reviewed under three headings: case-finding, case-reporting, and case-management. In all of these the physician must see that the patient adheres to the Sanitary Code, which requires isolation, disinfection of infectious material, etc. The physician must also see that the patient is coöperating in the treatment of his disease and that he remains under medical care. A number of cases who had been previously examined and reported by the private physician to the Health Department were picked up on the draft, but when the patient failed to return, the physician did nothing about it. Many of these cases at the time the physicians first reported them to the Health Department were minimal. At the time of their examination for Selective Service their condition was far advanced. If a patient with tuberculosis refuses to keep appointments made for him in his follow-up care or by his lack of coöperation endangers the public health, the Bureau for Tuberculosis should be notified. A letter is then sent to the patient to come to the Clinic, and if he fails to come a warrant is sworn out for his arrest.

As I have stated before, physicians should refer as many cases as possible to the Chest Clinics for roentgenograms. We might term this phase of it "individual mass X-rays." The physician is bound by law to see that all contacts of a known case of tuberculosis are examined. This part of the handling of a case is frequently omitted altogether. The examination in these cases can be made by either a private laboratory or by referring them to one of the Chest Clinics.

The official reporting of a tuberculosis case, in my opinion, should be of primary concern to all medical men, since it not only acts beneficially for the patient but also protects the community as a whole. It is only by the official reporting of a tuberculous individual that the various factors dealing with tuberculosis prevention and control are brought into play. Then the patient realizes that by this official report he is subject to the law of isolation and that his home is open to review in order that the other members of his family may be protected, at times even against the patient himself. It is through this medium that the Bureau for Tuberculosis contacts the physician to find out whether or not it can be of any help in the hospitalization of the patient or his education by the Public Health Nurse. The X-raying of contacts of an active case of tuberculosis is very important, because it eliminates the possibility of the patient, after sanatorium care, returning to an environment that may have been the cause of his original infection.

In the Bureau for Tuberculosis, at the present time, we have a Case Registry of 6,500 reported cases of tuberculosis. These cases are kept up to date by subsequent reports from physicians, hospitals, sanatoria, and clinics. This Central Registry shows the stage of disease and present activity, race, age and sex.

As you came in this evening you were handed two report cards for reporting tuberculosis cases. I trust that you will examine them very carefully, and should the occasion arise which requires the reporting of a case of tuberculosis, that the cards will be filled in completely so that the Bureau can have current knowledge of the morbidity for race, age and sex.

During the prewar years physicians responded very well in the reporting of cases under their care. Unfortunately the war broke down this record to a great degree. I trust that you will do all in your power to coöperate in seeing that the good record previously attained is again equaled. In case you physicians do not understand the scientific terminology of the report card, it would help materially, when reporting the case, if the X-ray report be enclosed.

I wish to take this opportunity to publicly express my appreciation to the pathologic and roentgenographic laboratories for their reporting to the Bureau positive tuberculosis findings. This has made it much easier for us, not only to have knowledge of a case of tuberculosis, but to contact the doctor who referred him for examination to see if the Bureau can be of any help.

Case management has become increasingly difficult due to the shortage in beds. Necessity demands that many patients awaiting hospitalization go out to public restaurants for their meals. The home situation in all of these cases has been investigated by the Nursing Bureau and is taken into consideration when the patients are placed on the waiting list for admission to the Sanatorium.

I strongly recommend to the members of the Medical Society that they utilize the public health nurses in the investigation of home conditions and the teaching of patients as regards isolation and protection of their families. Many doctors see the patient only in their offices and know little or nothing of the home situation or whether or not the patient has association with children.

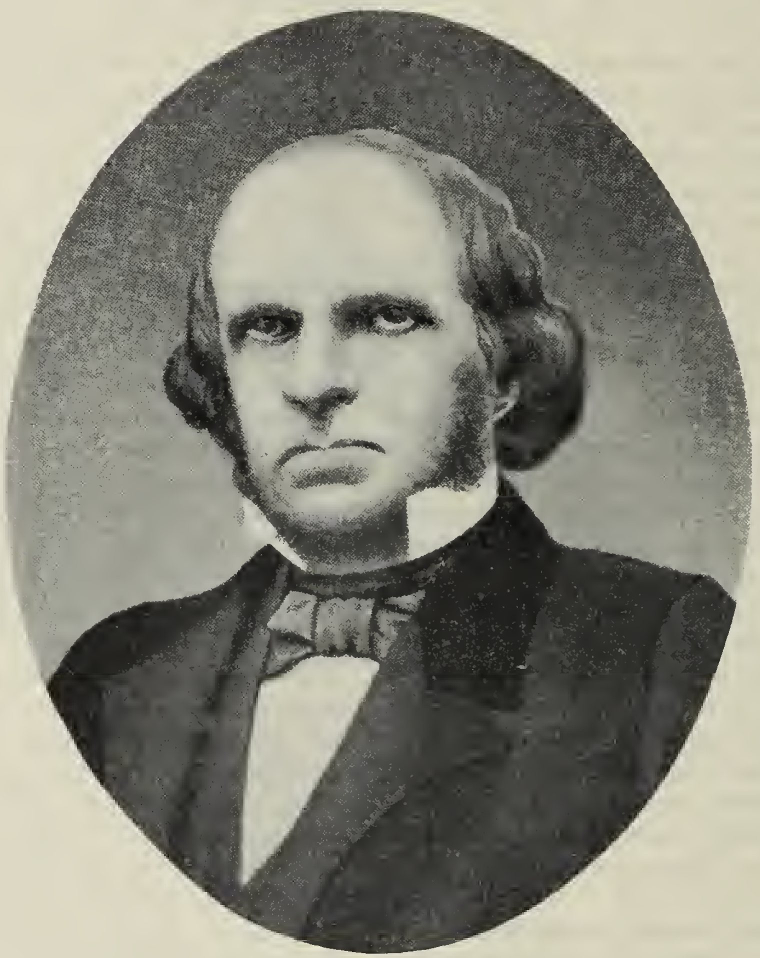
The management of post-sanatorium cases often presents a problem not only to men specializing in chest diseases but even more so to physicians in general practice. Organization of a rehabilitation program is fairly well under way in Glenn Dale Sanatorium and Freedmen's Hospital.

If at any time the personnel of the Bureau for Tuberculosis, in their case conferences, can be of any help to physicians handling such cases, I trust the physicians will avail themselves of this service.

In conclusion I might summarize by stressing these points:

1. The Bureau for Tuberculosis is charged with the control of tuberculosis.
2. Private physicians are responsible for seeing that the Sanitary Code is carried out.
3. Physicians could coöperate by having all cases under their care X-rayed either in public or private clinics.
4. Tuberculosis control can only be effective if the Medical Society, Tuberculosis Association, private physicians and the Bureau for Tuberculosis coordinate and correlate their work in this field.

Washington Physicians of Yesterday



HARVEY LINDSLY, M.D.

It seems that the medical profession of Washington was in the midst of one of its most trying periods when Dr. Harvey Lindsly was at the height of his professional career. His was a calming influence, it being said "he occupied a position of inoffensive neutrality." This undoubtedly accounted in a large measure for his popularity and his election to the presidency of the American Medical Association.

Born on January 11, 1804 in Morris County, New Jersey, he attended Princeton University, where he received his A.M. degree in 1820. He graduated from Columbian College, Washington, with the degree of Doctor of Medicine in 1828. He was Professor of the Practice of Medicine from 1845 to 1846. Dr. Lindsly was one of the founders of the Washington Infirmary, Pathological Society, and the Medical Association of the District of Columbia.

Much interested in public affairs, he worked diligently for improvements in the District. In 1859 when he gave the address of welcome to the AMA, then assembled in the city, he said, "The day is not far distant when, by the liberality of a great people, our public buildings, our literary and scientific institutions, our national parks and botanic gardens will be worthy of the grand metropolis of a nation which, perhaps within the next half century, will be the most populous, powerful and wealthy in Christendom."

Dr. Lindsly died April 28, 1889.

Military Affairs

SELECTIVE SERVICE HONORS ADDITIONAL PHYSICIANS

On April 30, in the Interdepartmental Auditorium, the Administration of Selective Service for the District of Columbia honored a second group of physicians and other personnel who had given generously of their time and talent, without compensation, to the successful operation of the organization known as the Selective Service System for the District of Columbia. The program followed closely the ceremonies of February 14, when the Congressional Certificate of Merit and Selective Service Medal were awarded to those officials who had served in the Selective Service System for more than two years on various boards. In this second group the majority of physicians had relinquished their duties during the war because of entering military service. These members therefore doubly distinguished themselves in the performance of patriotic duty.

Selected music by the Metropolitan Police Band preceded the advance of colors by the American Legion's National Guard of Honor. Following invocation by the Right Reverend John K. Cartwright, S.T.D., William E. Leahy introduced the speaker of the evening, Major General Lewis B. Hershey, U.S.A., Director of Selective Service. In words of affection and praise, Mr. Leahy credited General Hershey with having "built up the biggest army this country has ever built up, with the finest soldiers, and always with the people to a man behind him."

In a brief speech General Hershey paid tribute to those responsible for the job that had been done in the District of Columbia. He called attention to the fact that, when drafting began, in the same room where he was speaking was held the lottery which stated in which order the men should go. "In free men the privileges and obligations of military service are shared generally," he said. "The wisest thing Congress ever did was to have this decision made by people not salaried." Finally, he threw out this challenge: "What is there in peace that a community cannot do if they [the people] will use the same unflinching courage that they used in winning a war?"

General Hershey himself made the presentation of awards. Included among the recipients were the following members of the Medical Society of the District of Columbia:

Local Board Examining Physicians

William K. Billingsley
Abe Blajwas
Thomas Bradley
Crenshaw D. Briggs
Peter P. Brue
Warren B. Burch
John R. Cavanagh
Austin B. Chinn
Milton C. Cobey
Robert J. Coffey
Aloysius J. B. Connolly
Karl C. Corley
Darrell C. Crain
Worth B. Daniels
Max E. Feldman
Henry A. Grennan
Henry B. Gwynn
J. Phelps Hand, Jr.
Charles W. Harnsberger
Ralph J. Haws
Raymond T. Holden
Donald W. Ingham
Richard L. Jackson
Harvey F. Kreuzberg
Raymond Maret
John Minor
Ferdinand H. Mistretta
Edward W. Nicklas
John C. Reisinger
Alfred H. Richwine
Charles P. Ryland
Henry R. Schreiber
Leon Seley
Daniel Sondheimer
Philip A. E. Stebbing
Francis D. Threadgill
John W. Trenis

Medical Advisory Board Physicians in Military Service

Victor R. Alfaro
Morris I. Bierman†
Everett S. Caldemeyer
Alva D. Daughton
Harold R. Downey
James N. Greear
Henry T. Kulesher
Ralph L. Morrison*
Philip O. Pelland
John T. Schnebly
Maurice A. Selinger
G. Victor Simpson
William J. Tobin
T. Frasier Williams

A number of awards were made to members of the Medical Society who were not officially appointed to the System but who gave much of their time in various capacities. These were: Dr. Oscar B. Hunter, for his services in connection with Selective Service Examinations; Drs. Daniel L. Borden, James A. Lyon, A. Magruder MacDonald and Luther H. Reichelderfer†, for their services on the Committee on Medical Resources of the District Medical Society; and Dr. Paul F. Dickens, Chairman of Procurement and Assignment of Physicians for the District of Columbia.

Mrs. Bierman and Mrs. Reichelderfer accepted the awards in the names of their deceased husbands.

Special certificates of appreciation were awarded to a group of psychiatrists who contributed to the success of the Selective Service System by conducting psychiatric studies on a large group of registrants in 1940 and 1941 at Georgetown and George Washington Universities. In this group were the following Medical Society members:

Dexter M. Bullard
Addison M. Duval
Paul J. Ewerhardt
Alexander Halperin
Zigmond M. Lebensohn
Robert T. Morse
Manson B. Pettit

Certificates of appreciation were also awarded to the Superintendents and Staff of the following hospitals for their services in providing space and facilities for the conduct of the Selective Service examinations: Emergency, Freedmen's, Garfield Memorial, Georgetown University, Providence and Sibley Memorial.

Benediction was pronounced by the Reverend C. Leslie Glenn of St. John's Episcopal Church.

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† Deceased
* Dentist

U.S.P.H.S. OFFICERS SCHEDULED FOR RELEASE

Reserve officers on active duty with the United States Public Health Service who have accumulated 38 or more points as of September 30, 1945 will be released from active duty by June 1, 1946, according to a report made public, May 14, by Dr. Thomas Parran, Surgeon General, U. S. Public Health Service, Federal Security Agency. At monthly intervals thereafter, officers with totals of 34, 30, and 10 will be returned to civilian life. Points did not accumulate after September 30, 1945.

Any officer who previously had stated a desire for separation but who now wishes to remain in Service beyond his eligible date should notify the office of the Surgeon General, Dr. Parran stated.

Those officers who held reserve commissions in the Army under the Army Student Training Program and were released by the Army to accept commissions in the Public Health Service will be expected to serve the same length of time in the Public Health Service as they would have served had they remained in the Army.

MEMBERSHIP

The following applicants for membership were duly elected to membership at the meeting of the Executive Board, May 27, 1946, in accord with Amendment XI, Section 2, of the Constitution and By-laws of the Society:

Active Members

Lester L. Burtnick, 900—17th Street, N.W.
Samuel Burtoff, 4410—16th Street, N.W.
Eugene F. Finegan, 7239 Georgia Avenue, N.W.
James Q. Gant, Jr., 1726 M Street, N.W.
Camille R. Kurtz, 3130 Wisconsin Avenue, N.W.
William T. Lady, 800 Alabama Avenue, S.E.
Robert B. Nelson, Jr., 1824 Massachusetts Avenue, N.W.
Leonard T. Peterson, 1801 K Street, N.W.
Lawrence A. Rapee, 1340 Harvard Street, N.W.
Katherine K. Rice, 1302 Quincy Street, N.E.
John O. Schreiber, 237 North George Mason Drive, Arlington, Va.
Reuben Sorkin, 4221 South Capitol Street
Sherman A. Thomas, 3433 Connecticut Avenue, N.W.
George Tievsky, 2730 Wisconsin Avenue, N.W.

Associate Members

Otis R. Farley, St. Elizabeths Hospital
John A. Norcross, 9211 Georgia Avenue, Silver Spring, Md
Greenville B. Queen, 112 Willow Avenue, Takoma Park, Md.

The following applicants for membership will be voted on at the meeting of the Executive Board, July 29, 1946:

For Active Membership

Joseph Felix Belair, Georgetown University—1933
Alfred Homer Benson, Loyola University—1940
Raymond Franklin Chinn, George Washington University—1939
William Frank, Northwestern University—1943
Alfred R. Greenfield, University of Bern, Switzerland—1939
Dean Maeser Hayes, George Washington University—1940
Maurice H. Herzmark, George Washington University—1921
William Ladelle Howell, Baylor University—1928
Benjamin Paul Lafsky, George Washington University—1932
Sidney William Lowry, College of Medical Evangelists—1944
Thomas Francis McMahon, Georgetown University—1942
Carmon Robert Naples, Georgetown University—1932
David M. Nolan, Georgetown University—1938
Carlton Newman Price, University of Syracuse—1933
Alvin Seltzer, University of Illinois—1941
James Ward Sinclair, University of Toronto, Canada—1918
George R. Spence, Georgetown University—1939
Harold Sterling, University of Maryland—1943
George James Stuart, University of Bonn, Germany—1934
Charles Stanley White, Jr., George Washington University—1942

For Associate Membership

Hanson T. Perkins, George Washington University—1924

Recent changes in membership status:

Active to Associate

Mervin W. Glover
Joseph P. Kenrick
Arthur J. Mourot
Albert E. Pagan
T. Frasier Williams

Resigned

Active

Gerald A. Hopkins
George Tolstoi
Carl H. Wells, Jr.
Leila H. Wells

Associate

David E. Buckingham, D.V.M.
Arthur G. Compton
Ralph M. Crowley
Alfred Golden
William R. Osgood, Ph.D.
Charles E. Riggs
Leonard G. Rowntree

BOOKS RECEIVED FOR REVIEW

Acknowledgment is made of the following books which have been received for review:

Synopsis of Pathology. W. A. D. ANDERSON, M. A., M.D., F.A.C.P., Professor of Pathology and Bacteriology, Marquette University School of Medicine; Pathologist, St. Joseph's Hospital, Milwaukee, Wisconsin; formerly Associate Professor of Pathology, St. Louis University School of Medicine. Pp. 741, with 327 illustrations and 15 color plates. Price, $6.50. St. Louis: Mosby, 1946.

A History of Medicine. DOUGLAS GUTHRIE, M.D., F.R.C.S. ED., F.R.S.E. Pp. 448, with 72 plates. Price, $6.00. Philadelphia: Lippincott, 1946.

The Management of Fractures, Dislocations and Sprains. JOHN ALBERT KEY, B.S., M.D., Clinical Professor of Orthopedic Surgery, Washington University School of Medicine; Associate Surgeon, Barnes, Children's, and Jewish Hospitals, St. Louis, Mo., AND H. EARLE CONWELL, M.D., F.A.C.S., Orthopedic Surgeon to the Tennessee Coal, Iron and Railroad Company and the American Cast Iron Pipe Company; Chairman of the Committee on Fractures and Traumatic Surgery of the American Academy of Orthopedic Surgeons; member of

(*Continued on page 308*)

News and Personals

The Official Call of the American Medical Association to its officers, fellows and members announces that the 95th annual session of the Association will be held in San Francisco, California, from Monday, July 1, to Friday, July 5, 1946. The House of Delegates will convene on Monday, July 1.

The Scientific Assembly of the Association will open with the General Meeting on Tuesday, July 2, at 8 p.m. The various sections of the Scientific Assembly will meet Wednesday, July 3, at 9 a.m. and at 2 p.m. and subsequently according to their respective programs.

The campaign to raise $1,300,000 for a new building at **Children's Hospital** was launched at a banquet at the Mayflower Hotel, May 13. About 600 chairmen and workers attended. The principal speakers were Senator Joseph C. O'Mahoney of Wyoming, Chairman of the Subcommittee on Appropriations for the District, and Assistant Secretary of State William L. Clayton. Also called upon for brief remarks were Charles D. Drayton, President of the Board of Governors of Children's Hospital; Dr. Joseph S. Wall, Chief of the Medical Staff of the Hospital; Robert B. Swope, General Chairman of the campaign; and Ernest G. Draper, Chairman of the city-wide division of the campaign.

Dr. Wall has accepted the chairmanship of the campaign's medical staff division. Vice Chairman of the division is Dr. Edgar P. Copeland. Those appointed section leaders are Dr. W. F. Burdick, pediatrics; Dr. J. O. Warfield, surgery; Dr. S. A. Alexander, specialties; Dr. Isadore Lattman, laboratories; Dr. H. A. Ong, consulting staff; and Dr Mary Warner, resident staff. Dr. Warner is chief resident physician at Children's.

In addition to Mr. Draper and Dr. Wall, who are heading the two divisions mentioned above, the organization has set up five other division chairmen as follows: Martin T. Wiegand, counties group; Rear Admiral C. Russel Train, advance gifts; Clark G. Diamond, special gifts; Mrs. Karl A. Smith, nurses; and Dr. Walter A. Rath, dentists. The Arlington County drive will be led by Arthur Keene. Among his assistants is Dr. Robert H. Detwiler.

Physicians practicing at Children's Hospital were asked to support the drive at a special dinner meeting, May 2, in the Hotel 2400, which was attended by 105 doctors. Dr. Wall presided. Speakers were Mr. Swope and Drs. Burdick, Copeland, Charles A. Millwater and Frederick C. Fishback.

Proposed by-laws of the new **National Capital Area Hospital Council** were submitted to all hospitals in the District and nearby counties, May 14, by the Chairman of the recently appointed Organizing Committee, with the recommendation that a meeting be held by May 27 to set up the Council. The Organizing Committee was appointed, May 8, at the preliminary session of hospital officials held at Children's Hospital. Present were representatives of the Community Chest, Group Hospitalization, Inc., Hospital Superintendents' Association, the Washington Metropolitan Health Council, and the following hospitals: Alexandria, Arlington, Casualty, Children's, Columbia, Doctors, Episcopal Eye, Ear and Throat, Georgetown, Homeopathic, Providence, Sibley and Suburban.

Major General William D. Connor, of the Executive Committee of Emergency Hospital, was named Chairman of the Organizing Committee. Others appointed were Captain Chester Wells, President of the Board of Directors of Columbia Hospital; Sister Marie, Administrator, Providence Hospital; Robert G. Whitton, Administrator, Alexandria Hospital; and G. Thomas Dunlop, of Garfield Hospital Board.

It is contemplated that the new Council be composed of members and representatives. Members are to consist of charter-member hospitals and such other hospitals as shall be approved by the Council. Each member hospital would have three representatives, including two designated by its governing board, and a third who shall be the administrative head of the hospital. The Council members would consist of "such hospitals of Washington and the adjacent counties of Maryland and Virginia as are approved by the American College of Surgeons and shall join the Council."

A grant for the establishment of **125 fellowships to train physicians and sanitary engineers in public health** has just been approved by the National Foundation for Infantile Paralysis, according to an announcement just made by Surgeon General Thomas Parran of the U. S. Public Health Service.

Each fellowship provides a year's graduate training in a school of public health or a school of sanitary engineering. The fellowships will be administered by the Committee on Training of Public Health Personnel, which consists of representatives of schools of public health, the State and Territorial Health Officers, the American Public Health Association, and the U. S. Public Health Service.

The fellowships are available either during the academic year beginning in the fall of 1946 or the fall of 1947, and are open to men and women, citizens of the United States under 45 years of age. Applicants may secure further details by writing to the Surgeon General, U. S. Public Health Service, Attention: Public Health Training, 19th and Constitution Avenue, N.W., Washington 25, D. C. Owing to the anticipated heavy enrollment in graduate schools, completed applications for training in the fall term of 1946 should be filed promptly. The awards committee will act on applications on the following dates: June 15, July 1, July 15 and August 1.

The Surgeon General's Office has announced the appointment of an **Editorial Advisory Board on the History of the Medical Department of the Army in World War II.** As occasions demand, the Board will meet in Washington to review and discuss overall plans and policies for the preparation and publication of the history. Among the appointees are Colonel Albert G. Love, M.C. (retired), Chairman, former Director of the Historical Division, Office of the Surgeon General; Major General Paul R. Hawley (retired), Chief Medical Director, U. S. Veterans Administration; Brigadier General Raymond W. Bliss, The Deputy Surgeon General, U. S. Army; Brigadier General Malcolm C. Grew, The Air Surgeon, Army Air Forces; and Morris Fishbein, M.D., Editor, *Journal of the American Medical Association*

The Section on Gastroenterology held a dinner meeting and election of officers at the Mayflower Hotel, May 13. Dr. William Travis Gibb, Jr., former Chief of the Gastrointestinal Clinic, St. Luke's Hospital, New York City, spoke on "Clinical Aspects of Gastroscopy." The following officers were elected for 1946–47:

Dr. Fred A. J. Geier, *Chairman*; Dr. John E. Morris, *Vice Chairman*; Dr. Robert Sterling McGrath, *Secretary-Treasurer.*

At the meeting of the **Section on Neurology and Psychiatry,** May 16, the following officers were elected for 1946–47:

Dr. James W. Watts, *Chairman*; Dr. Isadore Rodis, *Vice Chairman*; Dr. Vasilios S. Lambros, *Secretary-Treasurer.*

The Section on Pediatrics met March 21 in the Library of Children's Hospital. Dr. Bernard J. Walsh read a paper on "Patent Ductus Arteriosus," which was followed by a discussion on surgical treatment by Dr. Edgar W. Davis. Plans for the Study of Child Health Services sponsored by the American Academy of Pediatrics were also presented.

Officers elected for the coming year were as follows:

Dr. John A. Washington, *Chairman*; Dr. Harold M. Hobart, *Vice Chairman*; Dr. George Maksim, *Secretary-Treasurer.*

Members of the Board of the newly organized **Maryland and District of Columbia Association to Control Epilepsy** held a meeting, May 7, at Children's Hospital. Dr. Joseph W. Stein presided. The immediate objectives decided upon were:

To establish an information center in both Washington and Baltimore dealing with the education, employment, treatment and rehabilitation of epileptics.

To expand the Bowditch Hospital School at Ruxton, Md., and eventually establish a similar school here. (This is the only school of its kind in the area. It can accommodate only 25 children at present.)

To establish an annual grant of funds to clinics in both Washington and Baltimore for the treatment of epileptic patients.

Meanwhile, the District Health Department opened the first clinic for epileptic patients, May 6. White patients will be treated in the Municipal Center under the direction of Dr. Leopold Wexberg, Director of the Bureau of Mental Hygiene. Negro patients will be examined in the Polk Health Center.

The George Washington University Medical Society held its final spring meeting, May 18, at the Medical School. Dr. J. B. Glenn, newly installed President of the Society, read the report of the retiring President, Dr. Fred A. J. Geier, emphasizing the Society's drive for 2,000 members. It now has 1,037. Newly elected officers are:

Dr. Clyde P. Reeves, *President-elect*; Dr. James B. Boyd, *First Vice President*; Dr. Dorothy Jaeger-Lee, *Second Vice President*; Dr. Oscar B. Hunter, *Secretary-Treasurer*; Dr. Geier, *Council member for a five-year term.*

The Washington Ophthalmological Society held its regular meeting, May 6, in the Medical Society's building. Dr. Harvey E. Thorpe of Pittsburgh, guest speaker, gave an address on "The Slit-lamp Microscope as an Aid to Differential Diagnosis in Ocular Disease." Two case presentations were made by Dr. J. Thomas Schnebly.

The District Tuberculosis Association, at its annual meeting, May 7, sponsored a forum discussion on the major gaps in Washington's tuberculosis control program. Speakers invited to present their views were Dr. William Earl Clark, President of the Medical Society of the District of Columbia, Miss Gertrude Bowling, Executive Director, Instructive Visiting Nurse Society; Dr. Sterling M. Lloyd, of the Medico-Chirurgical Society, Inc.; Mrs. Arthur Watkins, President of the District Congress of Parents and Teachers; and Dr. Roy Lyman Sexton, Chairman of the Public Health Committee of the Washington Board of Trade.

Members of the Medical Society elected to the Association's Board of Directors were Drs. John W. Trenis, W. LeRoy Dunn, and James J. Feffer. Miss Jane Hoey, President of the Association, was reelected to that office.

About 200 members and guests of the **Georgetown Clinical Society** enjoyed an outing, May 16, at the Manor Country Club in Maryland. Dr. Raymond C. Kirchner, President of the Society, presided at the dinner following an afternoon of golf.

Officers who have been elected to serve during 1946–47 are:

Dr. Michael J. McInerney, *President*; Dr. Robert F. Costello, *Vice President;* Dr. Hugh H. Hussey, *Secretary-Treasurer.*

At a special meeting of **medical alumni of George Washington University,** May 16, plans were discussed for building a new George Washington University Medical School after completion of the new Hospital. Dr. Cloyd H. Marvin, President of the University, said long-range plans call for the erection of the Medical School in the immediate vicinity of the Hospital, which is located between 22nd and 23rd Streets, N.W., and Washington Circle and I Street, N.W.

Other speakers at the meeting included Leo G. Schmelzer, Superintendent of the Hospital, and Dr. Walter A. Bloedorn, Dean of the Medical School. Dr. Fred A. J. Geier, Vice President of the Medical Section of the Alumni Association, presided.

Dr. Peyton Rous was selected the **Kober Memorial Lecturer for 1946** by the Association of American Physicians. His address on "Evolution of a Cancer" was delivered before a large group of physicians and scientists in Gaston Hall, Georgetown University, April 25.

Dr. Rous, recipient of the Kober certificate and $500 honorarium, is a member of the Rockefeller Institute for Medical Research and former Vice Chairman of the Division of Medicine of the National Research Council. He was introduced to the audience by Dr. John D. Hird, Executive Secretary of the School of Medicine.

Golf and dinner at the Kenwood Country Club were the order of the day for the **Louis Mackall Medical Society,** May 15. About 100 members and guests were present, including three honorary members, Drs. A. Y. P. Garnett, Thomas E. Neill and John D. Thomas.

Dr. Beveridge Miller, President of the Society, presided at the dinner in the evening, while Dr. Norvell Belt acted as master of ceremonies for the entertainment which followed. Dr. Russel J. Jansen was awarded the Kloman Cup.

At the April meeting the following members were elected to office for the coming year:

Dr. James E. Wissler, *President*; Dr. Walter Atkinson, *Vice President*; Dr. Leo B. Gaffney, *Secretary-Treasurer.*

The International Medical Club held a luncheon, May 15, at the Mayflower Hotel in honor of Dr. J. Guiterrez Osorio, Surgeon General of the Venezuelan

Army, and Professor Raymond Darget, Professor of Urology from the University of Bordeaux. Dr. Walter A. Bloedorn, President of the Club, presided.

Drs. Edgar E. Quayle, William H. Jenkins and James P. Lyons were elected to membership in the Club.

Dr. Daniel B. Moffett was host to the **Clinico-Pathological Society,** May 7, at his home on Hawthorne Street. The following program was presented during the evening: "Chest Tumors and Routine Examinations," Dr. Janvier Lindsay; "Retention of Urine in Children from Extra-vesicle Pathology," Dr. Charles P. Howze.

New officers for **St. Elizabeths Medical Society,** elected at the Society's ninth annual meeting, April 26, were the following:

Dr. George D. Weickhardt, *President*; Dr. James W. Watts, *Vice President*; Dr. Morris Kleinerman, *Secretary-Treasurer.*

The Executive Board, at its meeting, April 22, approved the appointment of the following members to the new **Committee on Compensation Insurance:** Dr. W. Cabell Moore, *Chairman*, Dr. Frank E. Gantz and Dr. Donald W. Mitchell.

A bronze tablet was dedicated at **Doctors Hospital,** May 16, marking it as the site occupied by the Sidwell Friends School and Friends Meeting House from 1810 to 1938, when it was sold that the Hospital might be erected. Dr. William Earl Clark, Vice President of the Hospital, and Dr. Oscar B. Hunter, Secretary, received the memorial from Mr. Albert Stabler, who at 83 years is the second oldest surviving member of the old Meeting House. The dedication of the plaque was a feature of Founder's Day at the School, observed annually on the birthday of the founder, Thomas W. Sidwell.

Drs. W. Warren Sager, Raymond T. Holden and John Minor have been appointed to the Deans' Committee of Georgetown and George Washington University Medical Schools, which selects consultants for the visiting staff of Mt. Alto Hospital.

Major General George F. Lull, U.S.A. (retired), Secretary and General Manager of the American Medical Association, was a visitor at the Society's offices, May 6.

Dr. Morris Fishbein, Editor of the *Journal of the AMA*, spoke at the Rotary Club luncheon at the Willard Hotel, May 8. Dr. Fishbein gave his views in favor of voluntary medical insurance as opposed to compulsory health insurance.

Dr. Harold J. Jeghers of Boston has been named Professor and Director of the Department of Medicine at the **Georgetown University School of Medicine** and Physician-in-Chief of **Georgetown University Hospital,** effective July 1, 1946.

Dr. Jeghers was born in Jersey City, New Jersey, September 26, 1904. He received his medical degree from the Western Reserve University School of Medicine in 1932. After graduation he served as intern and resident in medicine on the Boston University Medical Service at the Boston City Hospital and as research fellow at the Evans Memorial Institute for Medical Research. Following this, he joined the faculty of Boston University School of Medicine in 1935, where he is now Associate Professor of Medicine. He has been a member of the staff of the Boston City Hospital since 1937 and at present is Physician-in-Chief of the Fifth Medical Service. He has also been associated with the Evans Memorial Hospital since 1939 as assistant physician on the clinical staff. Dr. Jeghers has been active in medical research, is a frequent contributor to the medical literature, and is a member of several scientific societies, including the American College of Physicians, of which he is a Fellow, the American Society for Clinical Investigation, and Sigma Xi.

The appointment of **Dr. James N. Greear, Jr.,** to the Board of Trustees of Group Hospitalization, Inc., was announced, May 16, by Joseph H. Himes, President of the Board. The appointment was made with the approval of the Medical Society and upon the recommendation of the Executive Board. Dr. Greear was President of the District Medical Society during 1944–45.

A large delegation of Washington physicians attended the first annual session since the War of the **American College of Physicians,** held in Philadelphia, May 13–17.

Dr. Wallace M. Yater, in conjunction with Major

Aaron H. Traum of the Veterans Administration and Major Wilson G. Brown of the Army Institute of Pathology, gave a lecture, May 17, on "Coronary Artery Disease in the 18–39 Year Age Group (a Study of 800 Cases)." Dr. Yater and **Dr. Joseph T. Roberts,** Chief Medical Officer of Gallinger Municipal Hospital, presented a paper at the same meeting on the subject, "Globin Insulin and Protamine Zinc Insulin: a Comparison of Their Use in Equal Doses."

Dr. Yater also participated in a Clinical Pathologic Conference at the Philadelphia General Hospital during the week.

Colonel Wallace H. Graham, personal physician to President Truman, received the Chevalier of the Legion of Honor and the Croix de Guerre, May 2, for services in Normandy. Colonel Graham was cited for caring personally for wounded French soldiers while serving as Chief of the Surgical Service of the 24th Evacuation Hospital.

The 47th Annual Meeting of the **American Therapeutic Society** was held in Atlantic City, New Jersey, May 11 and 12. **Dr. Oscar B. Hunter,** Secretary of the Society, presented his report at the business meeting, May 11. Among those who participated in the scientific session were **Dr. Oscar B. Hunter, Jr.,** who presented a paper on "Correlation of Laboratory Findings with Therapy in Epidemic Hepatitis," and **Dr. S. Arthur Linde,** who collaborated with Dr. Harry E. Bacon, Philadelphia, on a paper entitled, "The Surgical Treatment of Diverticulitis." **Dr. Alphonse McMahon** was toastmaster at the annual banquet.

The American Dermatological Association, Inc., held its annual meeting, June 10–13, at The Homestead, Hot Springs, Va. At the Association dinner, June 10, **Dr. Lee McCarthy** was the principal speaker; his subject, "Some Aspects of Military Medical Intelligence."

Dr. Frank J. Eichenlaub, in collaboration with **Dr. Raymond A. Osbourn,** presented a paper on "Relation of Liver Disease to Congestive Eczema," at the scientific session, June 12.

Attending the **Middle Atlantic States Regional Conference** at Philadelphia, May 9, were **Dr. Daniel L. Borden, Dr. Joseph S. Lawrence, and Theodore Wiprud.** Dr. Lawrence gave a report on the hearings of the Wagner-Murray-Dingell bill, while Dr. Borden and Mr. Wiprud were present as representatives of the Committee on Medical Care.

Dr. Darrell C. Crain spoke on "Epidemic Tropical Arthritis" before the annual meeting of the American Rheumatism Association in New York City, May 24.

Dr. Crain invited a group of physicians to his home, June 4, for the purpose of discussing a proposed District of Columbia Rheumatism Society.

Drs. William A. Morgan, Roy L. Sexton and Richard K. Thompson appeared before the **D. C. Dental Society,** May 14, to talk on "Dental Hygiene and Nutrition in the Far North." Dr. Sexton gave an illustrated lecture on "The History of the Alaskan Fur Seals."

Dr. Leonard G. Rowntree, Chairman of the National Medical Advisory Board of the American Legion, has announced a contribution by that organization of $50,000 to the American Heart Association to combat rheumatic fever and heart disease. Dr. Rowntree, well known in Washington, was formerly Chief of the Selective Service Medical Division.

Theodore Wiprud attended, by invitation, the President's Safety Conference, which was held in the Departmental Auditorium, May 8–10.

Dr. A. Barklie Coulter, Director of the District Bureau for Tuberculosis, was the guest speaker at a meeting of the Federation of Citizens' Associations, April 20.

Dr. Leopold Wexberg, Director of the District Bureau of Mental Hygiene, spoke on psychiatric needs of socially handicapped children at a meeting of Neighborhood Councils at the Y.W.C.A., May 1.

Dr. Lewis K. Sweet, Chief Medical Officer in Pediatrics at Gallinger Municipal Hospital, gave a radio address, May 6, over WRC. His talk was the second in a series presented during "Nurse Recruiting Week" to stimulate interest among young women in nursing courses.

Theodore Wiprud, the Medical Society's Secretary, was one of three participants in a radio program sponsored by the National Grange, May 19, on the subject, "Should we have compulsory health insurance?" Speaking in the affirmative was Nelson Cruickshank, Director of Social Insurance Activities of the American Federation of Labor, while Mr. Wiprud and Dr. Lloyd C. Halvorson, Director of Economic Research, National Grange, presented the negative viewpoint, referring particularly to the Wagner-Murray-Dingell bill now pending.

This program was one of the America United Series, originating in WRC, which is heard each Sunday at 12:15 p.m. over the NBC network of about 100 stations, and sponsored by labor, agriculture and business organizations.

Dr. R. Lomax Wells attended the 31st session of the American Association of Industrial Physicians and Surgeons which met in Chicago during the week of April 8.

EDWIN ATKINS MERRITT, M.D.

(1880–1946)

Dr. Edwin A. Merritt, Director of the Warwick Memorial Clinic, Garfield Hospital, and one of the Nation's foremost radiologists, died April 9 in St. Petersburg, Florida, where he had gone for a brief vacation.

Dr. Merritt was born in Red Oak, Iowa, on April 5, 1880, the son of William W. Merritt, a Universalist minister. His ancestry goes back to the earliest days of New England. In many traits of his forceful character he reflected the rugged stock from which he came. His most prominent characteristics included a love of freedom and a deep and sincere patriotism. These were a part of his heritage from his English and New England forebears, but must have been deepened and intensified by his early education in Potsdam, N. Y., in the home of his uncle, General Edwin Atkins Merritt, for whom he was named, and who had a long and honorable career in the Civil War and in the political life of his state.

Dr. Merritt enrolled for medical training at the Omaha Medical College, which merged with the University of Nebraska in 1903. The following year he received his degree in medicine. Several years later he completed a year of postgraduate study at Rush Medical College, Chicago.

Ed Merritt's love of country was no mere "lip service." When only a boy he enlisted as a private in the Army and served in the Philippine Islands. In World War I he was a Major in the Medical Corps, and at his own urgent solicitation went to France early in 1918. There he was Chief of the Radiological Service of the First Army before and during the entire Argonne offensive, and later occupied the same position with the Army of Occupation in Germany, with the rank of Lieutenant Colonel. He filled those important positions with the energy and ability that have characterized the work of his entire career.

Edwin A. Merritt, M.D.

In 1919, soon after the end of World War I, Dr. Merritt settled in Washington as associate of Dr. Arthur C. Christie and the late Dr. Thomas A. Groover, an association that endured until his death.

Although Dr. Merritt was a radiologist of great ability in the diagnostic field, his life-long interest was in the treatment of cancer. He had a confidence in the efficacy of radiation treatment of cancer which led him to advocate this method with almost evangelistic zeal. Those who are best acquainted with his results believe that when finally published they will justify his confidence, especially in cancer of the cervix uteri.

In character Ed Merritt was rugged and forceful and at times uncompromising when his convictions were involved. Above everything he hated a sham. At heart he was an idealist who loved people. He looked upon every patient as an individual who was in trouble and in need of his help. He had a great love for beauty in nature which manifested itself in the development of a beautiful garden of over seven acres surrounding his home. In it are innumerable trees and flowers and shrubs, many of which he had propagated himself by grafting and hybridization to produce new varieties. In pursuit of this interest he was a member of the American Horticultural Society, the Horticultural Society of New York, and the American Orchid Society, and was the author of several articles on horticultural subjects.

In his professional life Dr. Merritt was devoted to the specialty of radiology, but primarily he was a physician who had begun his career in general practice. Throughout his life he remained a clinician of unusual ability. He became what must be the ideal of every radiologist, a consultant in medicine who enjoys the confidence and respect of his colleagues. He was Clinical Professor of Radiology of Georgetown University School of Medicine, and a diplomate of the American Board of Radiology. In 1933 he was selected by the Executive Committee of the District Medical Society to deliver the biennial Davidson Lecture. His membership in scientific organizations included the American Medical Association, of which he was a Fellow, the Medical Society of the District of Columbia, the Southern Medical Association, the American Roentgen Ray Society, the American Cancer Society, the American College of Radiology, and the Clinico-Pathological Society.

Surviving him are his wife, Mrs. Dessa Rathbone Merritt, a son, John W. Merritt, and a daughter, Mrs. Virginia M. McPeak, all of Washington; a brother, Dr. John P. Merritt, Omaha, Nebr.; and a sister, Mrs. Cornelia Milner, of Red Oak, Iowa. The family resides at 9312 Connecticut Avenue, N. W.

Dr. Merritt was in many respects a unique personality. He had a capacity for friendship that was unusual, a faith in the possibility of progress that never faltered, and a courage in standing for his convictions that never failed. His memory will be cherished by his friends throughout their lives and will be respected and honored by all who knew him.

Arthur C. Christie, M.D.

JAMES FOSTER SCOTT, M.D.
(1863–1946)

Dr. James Foster Scott, retired physician, died February 20, 1946, in Emergency Hospital, at the age of 83 years. He had resided at McLean, Virginia, for the past 35 years.

Dr. Scott was born in Futteguhr, India, in 1863, the son of American missionary parents, and came to the United States at the age of four years. He attended Hastings Academy, in Philadelphia, and received his Bachelor of Arts degree from Yale University in 1884. Four years later, 1888, he received his degree in medicine from the University of Edinburgh, Scotland. The following year he spent in postgraduate study in Vienna.

Dr. Scott began practicing medicine in the District of Columbia in 1889. For two years, 1896-98, he was in charge of Columbia Hospital. In the gold rush of 1898 he went to Alaska to satisfy his desire for exploration as well as to practice medicine. His adventures are related by Mary Lee Davis in a book called "Sourdough Gold."

After returning to the States, Dr. Scott retired from the practice of medicine and moved to McLean, Virginia. There he devoted his time to writing a book on his philosophy of life, which had not been completed at the time of his death.

Dr. Scott was elected to Active membership in the Medical Association of the District of Columbia in 1891. He transferred to Associate membership in the Medical Society in 1920, in which status he continued until his death.

Surviving him is his wife, Mrs. Karen Gram Scott, of McLean, Va.

Intravenous Amino Acids—White

(*Continued from page 258*)

consideration one of the major factors that determine the cause of the disease or is responsible for its complications. It is now possible to raise the plasma protein level and maintain a nitrogen balance with the use of solutions available in any good institution, but some judgment and laboratory studies are essential to achieve the best results. We have stressed the surgical viewpoint, but the internist will find much in the subject applicable to a large part of his practice.

Lord Moynihan made a statement that will bear repeating, since it seems rather apropos: "We have now made surgery safe for the patient, and now we must make the patient safe for surgery."

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Child Psychology—Stokes

(*Continued from page 261*)

sexual ideals and conduct. And I would stress my conviction that children will live up to fine social ideals if given all the facts, lots of faith and good will, and a wise, flexible tolerance of their occasional mistakes. Indeed, with these breaks they will surely be a happier, more vital, kinder generation than our own.

Let no one suppose that the problem of raising children to emotional maturity has become easy for anyone or that it can be effortlessly effected by any simple new formula. On the contrary, successful parenthood must always require a great deal of time and energy given in an affectionate spirit and without demand for reward. Only so can children become free and mature persons capable of genuine affection for those fellow human beings beside whom they grew up, their parents.

Discipline and guidance are serious and inescapable parental responsibilities and often present trying situations. But it is amazing how the problem of discipline is eased when parental demands are considerate, reasonable, and expressed without hostility. The parent who does not strive for such an attitude will meet trouble accordingly, and certainly he, not the child, is at fault.

What has been presented in this short discussion is indeed a hasty sketch of the subject, but I hope that it may stimulate your thoughts and your actions in a field of the liveliest concern to every one of us.

1835 Eye Street, N. W.

Free Skin Grafts—Dick

(*Continued from page 264*)

(fig. 10). A plastic conformer maintained the created socket until healing was complete (fig. 11). Minor procedures for extending the canthi and use of a plastic eye change the patient's appearance considerably.

Figures 12 and 13 demonstrate healing by scar following a third degree burn of the face involving upper and lower eyelids with resulting severe ectropion. The correction by free graft restores protection to the globe.

SUMMARY AND CONCLUSION

Cases have been presented showing the utility of free skin for reconstruction under unfavorable conditions. Technical details of preparation, application and thickness of tissue required have been omitted for brevity. The cases presented required skin varying from the thinnest to full thickness, depending on the recipient site, final result desired, and the demands of stress it was intended to withstand.

Footnotes—Observer

(*Continued from page 285*)

the House District Committee, introduced a bill providing for voluntary admissions to St. Elizabeths Hospital. This legislation still has to come before the Committee. A companion bill, it is hoped, will be introduced shortly in the Senate. . . . Your Observer has wondered if there is sufficient interest to warrant establishing a new department, "Open Forum," in the MEDICAL ANNALS. The Editorial Board has taken pride in the fact that its columns are open to discussion of all sides of a question. The "Forum" would provide an opportunity for members to express themselves on any subject. Your Observer would be interested in reactions of readers to this suggestion. . . . Few Washington physicians will loom larger in medical history than Dr. Joseph S. Wall. Not only is he a great physician but a fine gentleman whose charming qualities are appreciated by all who know him. Dr. Wall will have completed fifty years' service in Children's Hospital on October 1. . . . People, even the so-called intellectuals, are surprisingly gullible where their health is concerned. Army Air Force surgeons, according to the *New York Times*, acting mainly "for the sake of morale," felt called upon to expose guinea pigs to radar waves because of rumors that mysterious radar waves produced all kinds of ill effects on human beings, including baldness and sterility.

T. W.

Annual Report of Woman's Auxiliary

(*Continued from page 290*)

I feel truly honored to have served as President of the Woman's Auxiliary. I wish to express my appreciation and gratitude to the Executive Board and the members of their committees, and to the members of the Auxiliary for their work and coöperation. To Mrs. A. Magruder MacDonald, our Parliamentarian, I want to give special thanks for her constant assistance and guidance. It has been a pleasure to work with them all.

MRS. WILLIAM EARL CLARK
President

Books Received for Review

(*Continued from page 299*)

the Fracture Committee of the American College of Surgeons; Associate Surgical Director of the Crippled Children's Hospital, Attending Orthopedic Surgeon to St. Vincent's Hospital, South Highlands Hospital, Jefferson-Hillman Hospital, Children's Hospital and Baptist Hospitals, Birmingham, Alabama. Pp. 1322, illustrated. Price, $12.50. St. Louis: Mosby, 1946.

Studies in Deficiency Disease. ROBERT MCCARRISON, M.D., D.Sc., HON.LL.D. (Belf.), Fellow of the Royal College of Physicians, London; Laureat de L'Academie de Medecine, Paris; Honorary Surgeon to the Viceroy of India; Lieutenant-Colonel, Indian Medical Service. Pp. 270, with 82 illustrations. London: Henry Frowde and Hodder & Stoughton, 1921. Reproduced by photolithography, 1945, by Lee Foundation for Nutritional Research, Milwaukee, Wis.

A Bibliography of Infantile Paralysis, 1789–1944, with Selected Abstracts and Annotations, prepared under direction of the National Foundation for Infantile Paralysis, Inc. Edited by MORRIS FISHBEIN, M.D., Editor, *Journal of the American Medical Association;* compiled by LUDVIG HEKTOEN, M.D., Chief Editor, *Archives of Pathology*, AND ELLA M. SALMONSEN, Medical Reference Librarian, John Crerar Library, Chicago. Pp. 672. Philadelphia: Lippincott, 1946.

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RECENT ADVANCES IN ORTHOPEDIC SURGERY

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Washington

AT LEAST one volume could be written on this subject, if the discussion included complete reporting and evaluation of the advances which have taken place in this field in the past few years. In a paper of the present scope, one must be content only to mention a few of the more striking features and to hope that the reader who is interested will pursue further the subject which arouses his particular interest. We shall hope that even a limited discussion will enable the reader to realize that progress is being made, and that what was true for a given case or condition five years ago is by no means necessarily true now.

Experience in war casualties has served to emphasize the importance of already well known, fundamental surgical principles. In spite of the tremendous value of the sulfonamides and the antibiotics, such as penicillin, it has been proved that nothing has yet replaced thorough excision of compound or infected wounds. It has been shown that complete excision, preceded and followed by adequate physiologic support, and assisted by chemotherapy and antibiotics gives the expectation of complete and relatively prompt recovery in cases which once were doomed to a lifetime of disability and continued treatment. Early skin grafting is indicated in any case in which there is not active infection, if normal skin cannot be drawn over the wound without tension.

Treatment of chronic, draining sinuses in osteomyelitis seems to be more successful if hourly injections of penicillin in combination with a wetting agent are used along with systemic therapy. In those cases which do not respond to this conservative régime, there is still available the more radical method of excision and skin grafting.

Although one publication has indicated that certain cases were receiving larger doses of penicillin than were necessary, other studies have shown that in some cases enormous amounts, up to half a million units or more in 24 hours, were effective when conventional dosage had no effect. On the whole, it seems unwise to encourage minimal dosage with an agent when large amounts have no undesirable effect, and when suboptimal amounts may destroy any chance of success in the treatment of that individual.

In connection with the antibiotics it should be borne in mind that, as time goes on, new drugs will have to be developed as pathogenic organisms develop increased resistance to the therapeutic agents now available.

There is increasing emphasis on the nutritional care of patients. Inadequate protein intake with a negative nitrogen balance has been shown objectively to be detrimental to healing of both bone and soft tissue wounds. More care is being taken to assure adequate vitamin intake. The more closely the entire physiology can be made to approximate the normal, the more promptly and surely the patient will recover.

Much study has been expended on the pathogenesis, avoidance and treatment of shock. There is an increasing tendency toward supportive transfusion of blood or plasma during surgical procedures and immediately following severe trauma, regardless of the seeming state of well-being of the patient at the time. The best treatment of shock is prevention. Many procedures which would not have been possible without great risk are now performed with confidence, simply because of the increased appreciation of the importance of blood and fluid loss during surgery.

Refrigeration anesthesia has been studied by several investigators and has been the subject of numerous publications. In spite of one publication which indicated that results were as good with ordinary anesthetics, properly selected and administered, as with refrigeration, it is difficult not to believe that this procedure has been a definite contribution and is acutally lifesaving in some cases.

Although publications continue to appear on the management of rheumatoid arthritis, the fact remains that the prognosis remains much the same now as it was ten years ago. No striking contributions have been made, although some workers feel that colloidal gold offers hope for some cases. Alternate hydration and dehydration may offer more than any other form of treatment used at present, but this treatment is still in the investigative stage, and reliable reports will not be forthcoming for another year or two.

An ingenious procedure has been described to minimize the difficulty in exposing the proximal ends of severed tendons in the forearm. A soft rubber tube is wrapped around the forearm, from the proximal end toward the distal end. This milks the tendon ends down into the incision, and makes it unnecessary to extend the incision unduly. It helps also to stabilize the proximal ends while the tendon surgery is being performed.

For removing a ring from a swollen finger, a procedure has been described which renders unnecessary the cutting of the ring. A piece of string is soaped and wound closely, in tight coils, around the finger, proceeding from the distal end toward the proximal end. The free end of the string is then passed beneath the ring with a ligature carrier or a loop of tonsil wire. As the free end of the string is then unwound, the ring is slipped slowly off the finger.

A rather common cause of intractable metatarsalgia has been discovered to be a fibrous or fatty tumor involving the lateral branch of the medial plantar nerve. Excision of the involved portion of the nerve results in complete relief.

Authenticated cases of injury to the intervertebral disc resulting from faulty technic in spinal puncture are finding their way into the literature in increasing numbers. This complication must be borne in mind as a real entity, not as a remote possibility.

There has been a renewed wave of enthusiasm for the novocaine injection treatment of sprained ankle, such as the wave which appeared in 1928, after Bohler's first English translation appeared in this country. It has seemed to me, after having used the method in a large number of cases, that there is little justification in chancing infection, even though the risk be remote, when the condition can be treated with full satisfaction by methods which involve no risk. Once one has observed a minor condition, such as a sprained ankle, converted into an osteomyelitis, he is chary of the use of an agent which has been demonstrated to produce such an unfortunate result. Adequate taping, either at the time of the injury or at any time thereafter, will enable the patient to resume his usual activities at once, without the risk of any damage.

Tennis elbows continue to be recalcitrant under conservative treatment, in spite of published reports to the contrary.

Painful shoulders are becoming better understood. The work of McLaughlin and Neviaser, among others, has helped to clarify the pathology of certain symptom complexes. Painful supraspinatus nodules may cause pain in the entire upper extremity or in the neck. Disc lesions in the cervical spine are responsible for certain intractable cases. Attention to the neck and back, as well as the shoulder, will lead to the proper diagnosis and treatment in cases in which examination of the shoulder alone proves fruitless. The scalenus syndrome is waning in popularity as further research discloses the causes of the syndrome to lie in other tissues than the muscle. Anomalies of the first rib can be as fruitful causes of shoulder and arm pain as any other lesion. A case was seen recently in which the presenting symptom was pain in the arm. The cause of the pain was found to be a mediastinal neoplasm. It has been demonstrated that thrombosis of the subclavian artery can be the result of holding the hand over the head, with compression of the artery between the clavicle and the first rib. Certain more chronic pains around the neck may have their origin as the result of a similar mechanism.

Bankart of England has made in recent years probably the most important contribution to the understanding of the pathology of recurrent dislocation of the shoulder. Almost without exception, his findings in these cases have been verified by surgeons throughout the world, and his method of repair has been adopted by more workers each year. The reparative procedure is technically more difficult than most of the procedures for this condition, but its basis in sound pathology and its clinical results justify the added difficulty. Magnuson has described a procedure for recurrent dislocation of the shoulder which appears to be easy to do and effective in preventing redislocation. There is a rather marked limitation of external rotation following the procedure.

Fibrous dysplasia of bone, a condition which has been recognized for at least twelve years, has come into prominence in the past three or four years as a result of the work of Allbright and Fuller, among others. This condition is often diagnosed as giant cell tumor or bone cyst, but the characteristic features in the X-ray film, which have been pointed out by Hampton, permit differentiation in most cases, and allow the proper prognosis to be given.

Osteoid osteoma appears to be a clinical and pathologic entity. Complete excision of the small lesion responsible for the symptoms (pain and tenderness) results in complete and permanent cure.

Abbott has presented some of the best work of the last two years in his studies on the mechanics of the shoulder girdle. Understanding of the anatomy and function of the knee has been advanced by excellent studies by Voshell of Baltimore and Abbott of San Francisco. The tremendous volume of knee joint surgery in the armed services during the recent war has made us aware that there are many more pathologic conditions causing symptoms in this joint than were formerly generally recognized. Oxygen injection into the knee prior to X-ray examination furnishes invaluable information in certain cases. Recurrent locking as a result of incomplete meniscectomy has caused an increase in the use of the double capsular incision for exposure in cases of internal derangement of the knee. Only by the double incision can one be assured that he has removed the entire cartilage in cases of cartilage tears.

An increasing tendency toward allowing early weight bearing following arthrotomy of the knee seems to justify the practice which I have followed for the past nine years. My cases are helped to their feet, without the aid of crutches, on the day of operation. A paper describing the details of this care is in preparation. McKeever and others have used cellophane as interposition material in arthroplasties with good results and virtually no tissue reaction. There is no question that chemical and mechanical advances in totally unrelated fields are going to revolutionize the technical side of orthopedic surgery in the not too distant future.

New alloys have made available surgical wire which can be used from the finest to the heaviest work. This wire does not break when twisted, and is inert as to tissue reaction. Vitallium, which at first was brittle, has been improved so that plates can be bent and still retain their strength.

New instruments have appeared to simplify the technical difficulties of surgery in fractures and reconstructive procedures. The new, detachable handle, Lowman clamp, the Blount blade plate, the Goodwin clamp, the Engel-May guide for hip-nailing, the new forceps for holding tendons while they are being sutured, and the tendon cuff which obviates the necessity for tendon sutures are a few of these. Intramedullary splints for fractures have made their appearance and can be expected to attain increased prominence within the next few years.

Each year there are one or more additional devices for fixation of the fractured femoral neck, but the Smith-Petersen nail continues to hold the number one place in popularity. For some time it has appeared desirable to have a careful study to determine the cause of non-union in these fractures. Many such studies have appeared, but to the person who has seen many of these cases over a period of years and has followed the various explanations as they have appeared, there is always a considerable amount of dissatisfaction with the explanations and with the way in which the studies have been carried out.

Two controlled studies have been published recently which showed the advantage of traction treatment over either internal fixation or so-called Roger Anderson or Stader treatment in fractures of the femoral shaft. Theoretical advantages of the "newer" methods dissolve in the light of controlled studies of actual cases. It is evident that these procedures have a place which can be filled with success by no other treatment in certain cases, but experience with the methods and expert judgment are necessary, or the result may be much worse than if the usual methods had been used.

It has been pointed out repeatedly that full supination of the forearm is necessary in the treatment of supracondylar fractures of the elbow in children, in order to avoid cubitus varus deformity after the fixation is removed. In spite of this fact some writers still advise pronation. Common sense must make the decision in the individual case, but careful thought may be necessary to avoid unsightly and unnecessary deformities in certain of these cases.

Although statements are constantly made regarding the excellent results to be obtained in fractures of the calcaneum by the use of Bohler's method, personal investigation of available cases fails to substantiate such claims, except in those cases where comminution and vertical compression of the calcaneum are minimal. In badly comminuted cases and those involving the subtalar or calcaneocuboid joint to any considerable degree the best treatment is stabilization by operation. Severe fractures of the talus or the distal end of the tibia, with an obvious prospect of malfunction in the ankle, are being treated more and more by ankle fusion, without waiting for months or years after the injury.

There is at present an increasing tendency to advise exploration early in cases of traumatic conditions of the spine with neurologic findings. Certainly, the attitude of some men who defer such exploration until the last possible moment, or decry the procedure entirely, is receiving far less support than it has in the past.

Treatment of compression fractures of the spine without neurologic findings is apparently settled, but this may be the lull before a storm. Reduction of such fractures under general anesthesia, with forcible manipulation into hyperextension, is considered by some to be almost as bad as the injury itself. There are still advocates of the gradual, atraumatic hyperextension, and there are those who can show that a well-fitted brace gives at least as good immobilization as a hyperextension body jacket. When gravitational compression stress is removed by a hyperextension brace, there is no logic in keeping these patients in bed.

Fractures of the shaft and neck of the humerus are being treated with the hanging cast. This treatment, properly applied, is a definite advance in the treatment of these fractures. As one surgeon remarked, one does not apply traction to a fractured femur and return in 3 months expecting to find the fracture healed in good position. Alterations must be made in the mechanics of the hanging cast when the position is not satisfactory, just as similar alterations must be made in any other traction treatment. In the case of elderly patients with comminuted fractures of the head or neck of the humerus, it is usually unnecessary to use anything in addition to a sling in the daytime and a sling and swathe at night. Physiotherapy and motion within the limits of pain will then assure a satisfactory result with a minimum of restriction of these patients.

The hanging cast treatment has been described for intertrochanteric fractures of the femur, also. It seems to me that, given a competent operator who understands thoroughly the handling of fractures and this fracture in particular, one can be happier with internal fixation, either with the Blount blade plate or the Smith-Petersen nail with Thornton plate attached. In these cases the problem is not to get a union. Almost any of the methods will result in union in satisfactory position. The chief problem is the general care of the patient and the limitation of mortality to the lowest possible figures. It seems unnecessary to employ the femoral pin fixation with the free leg arrangement, such as Roger Anderson has described. Pins that are left protruding from the skin are more prone to be accompanied by infection than are pinless cases.

Many new appliances have been described for the nonsurgical care of certain orthopedic cases. A lengthy discussion is possible on this subject alone. The Baker back brace, which has been in use for some years, but which is not generally known, has the metal uprights in front instead of in the back. It maintains hyperextension of the upper part of the spine much better than the older style braces do. The Williams low back brace is another slightly unconventional appliance which maintains the lumbosacral joint in forward flexion instead of allowing lordosis at this joint. It is very useful in those cases in which it is felt desirable to maintain the greatest possible amount of room for the fifth lumbar root to pass through the intervertebral foramen.

There has been more general use of the skin tight plaster cast in the past few years. This method, if used with care, has obvious advantages over the padded cast technic. However, one must be expert in plaster work, or there will be pressure sores which will more than overbalance whatever advantage may be possessed by the nonpadded cast.

Arguments are still in progress concerning the treatment of bone ends and nerve trunks in amputations. Recent work has indicated that 2 per cent gentian violet injected into the nerve stump encourages the formation of a constricting scar around the nerve end with inhibition of production of neuroma.

Prognosis for cases of advanced hypertrophic arthritis of the knees with disabling pain and stiffness is much different from previous times. Surgery offers the difference between invalidism and activity. Aftercare in these cases is based upon thorough knowledge of the gross and microscopic pathology. Lack of such knowledge makes the difference between success and failure. The same remarks, both as to prognosis and indications, apply to backs and hips in the same condition.

The trend away from early operation and toward conservatism in the treatment of acute hematogenous osteomyelitis is becoming increasingly apparent. Such cases are treated by transfusion, hydration, penicillin and sulfonamides, and many of them go on to complete recovery without ever having been subjected to operation. Aspiration is playing an important part in certain cases in which accumulation of pus makes it unwise to neglect drainage. The old dictum, "Once an osteo always an osteo" is no longer supported by facts.

Nothing striking has appeared on the subject of scoliosis. It is not common enough knowledge, but a very good prognosis can be offered in cases of idiopathic scoliosis, if the patient is seen early and treatment is instituted before gross deformity has appeared. Even in these belated cases marked improvement can frequently be obtained.

It is still true of congenital dislocation of the hip that given a good surgeon and coöperative parents, one can almost invariably secure a hip which renders the patient normal psychologically and normal or close to normal functionally. It is true that several surgical procedures may be required, and that these cases should be followed to adult life or until they have a normal hip by X-ray examination and by function, but the time and trouble expended are always worthwhile.

Hiram Kite and Brockman have tried for years to impress certain fundamentals which are necessary in the treatment of congenital club-foot. Unfortunately, their teaching falls on barren soil at times. With good treatment a club-foot will be vitually normal, both functionally and anatomically. No advances in the treatment of this condition have been recorded. The best treatment is still plaster of paris casts, properly applied.

Operative fusion continues to be the best available treatment for tuberculous joints. There is an optimum time for the undertaking of this procedure, and this time must be determined by the orthopedic surgeon in the individual case. The coöperation of the pediatrician is essential to determine the general status of the patient's health and to rule out medical contraindications to operation. The Brittain fusion for tuberculosis of the hip consists of a bone graft passed from the shaft of the femur to the pelvis below the acetabulum. In this manner the joint space is avoided, and in cases in which there is extensive destruction about the inferior aspect of the socket with abscess formation such a fusion is of value. It is a complicated and difficult procedure and should not be lightly undertaken.

Orthopedic surgeons are counselling conservatism and thorough study before operation is undertaken for a ruptured intervertebral disc. The current epidemic of operative discomania is due to the teaching and action of a group of men who have never been trained in the mechanics of the skeletal system, and who as a natural result see only the nerve root irritation. As the years go by we see more and more recurrent back aches and sciatic pains which have been "cured" one or more times by the removal of loose disc tissue, while the fundamental abnormality which predisposed to the disc injury in the first place goes all unnoticed. I would like to emphasize that sciatic pain, with clinical and roentgenographic verification of the diagnosis of disc herniation is by no means, of itself, justification for operative removal of the disc. Many people with easily recognizable disc herniations and with a history of recurrent attacks of disabling pain from time to time are still able to go through life very satisfactorily without surgery. They play golf and they even play football in certain cases. The mere refusal of surgery for a disc is by no means a warrant for a hopeless life thereafter. I have a ruptured disc, but it has not been operated upon as yet,

(*Continued on page 358*)

THE ABSORPTION, DISTRIBUTION AND EXCRETION OF PENICILLIN*†

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AFTER the efficacy of a drug has been established, the rational approach to its clinical use depends on adequate studies of its absorption, distribution and excretion. In the 6 years that penicillin has been available numerous reports on this aspect of its pharmacology have appeared. Although some of the reports are conflicting, ample data have been accumulated so that the fate of the drug in the body is known.

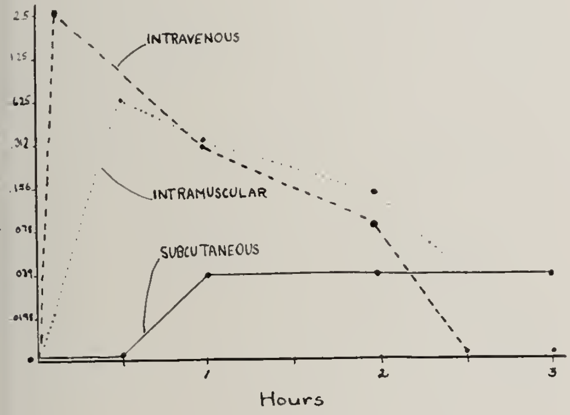

FIG. 1. Comparison of the curves of serum penicillin levels following injection of 25,000 units of penicillin by three parenteral routes.

Penicillin has been administered by every available route. Of these, the intravenous, intramuscular, subcutaneous and oral methods have received the most extensive study. In figure 1 a comparison has been made of the absorption curves when equivalent amounts of the drug are administered by the 3 parenteral routes. Following an intravenous injection of penicillin there is an immediate rise in the blood concentration with the peak level attained in several minutes. Thereafter there is a rapid, steady disappearance of the drug. After an intramuscular injection the level rises slowly, so that the maximum concentration is reached in 10 to 30 minutes. The drug disappears gradually, and, in general, is found in the blood for 30 to 45 minutes longer than an equivalent dose given intravenously. With subcutaneous injection the appearance of the drug in the blood is delayed for about an hour, and although it remains for several hours thereafter, the levels are usually insignificant. Recently several reports have appeared stating that subcutaneous administration of penicillin gives blood levels comparable to those obtained with equivalent dose administered intramuscularly.[1,2] Since these results have not been in agreement with those of several other investigators, it has been suggested that the penicillin was perhaps given intramuscularly rather than subcutaneously.

Since the intermittent intramuscular method of administration is the most commonly used, a table was prepared (table 1) indicating the period of time during which concentrations of penicillin, which have been found adequate for most infections, would be found in the blood following the injection of various doses of penicillin. These figures represent a compilation of the reports of other investigators[1–5] as well as our own studies.[6] In general, for every additional 5,000 units of penicillin injected up to 30,000 units the blood level will be prolonged about one-half hour. Thereafter the blood level is not prolonged proportionately to the increase in the dose, so that 50,000 units are needed to maintain a level for a period of 4 hours, 100,000 units for a period of 6 hours, and doses over 300,000 units do not prolong the blood level more than a period of 8 to 12 hours.

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* From the George Washington University Medical Division, Gallinger Municipal Hospital, and the George Washington University School of Medicine.

† Presented at the Intensive Postgraduate Course, George Washington University School of Medicine, March 11, 1946.

TABLE 1

Approximate Duration of Penicillin in Blood following Intramuscular Injection

DOSE (UNITS)	HOURS
5,000	½
10,000	1
15,000	1½
20,000	2
25,000	2½
30,000	3
50,000	4
100,000	6
300,000 to 800,000	8–12

The numerous difficulties inherent in the method of repeated injections have stimulated various investigators to perfect the continuous method of administration, employing the 3 parenteral routes. Some investigators believe that continuous intravenous injection is the method of choice.[7–9] Rantz and Kirby,[10] and Loewe and his co-workers[8] have reported that predictable, constant levels can be obtained by this method, and that a continuous concentration of 0.1 unit per c.c. of serum can be expected for each 100,000 units of penicillin administered over a 24-hour period. Others[5, 11, 12, 13] feel that, aside from the ease of administration by continuous intramuscular injection, the levels are higher than by continuous intravenous administration. Ory et al[5] have stated that less variation occurs in different patients and in the same patient with the continuous intramuscular method than when the intravenous method is used. Hirsh and Dowling[13] have shown that 200,000 units by continuous intramuscular infusion over a 24-hour period results in constant average level of 0.156 units per c.c. of serum, and that correspondingly higher concentrations can be obtained with larger doses. Rantz and Kirby[10] have reported that the continuous subcutaneous method yields serum levels 50 per cent as high as those obtained with a similar dose given by continuous intravenous administration, while Fleming and associates[1] believe the serum concentrations following subcutaneous infusion compare favorably with those obtained by the intramuscular method. The same objection to the excellent results reported with intermittent subcutaneous injection appears applicable to the results offered for the continuous method.

Oral administration of penicillin is the desirable method. Shortly after the introduction of penicillin it was learned that penicillin may be destroyed by the gastric juice, and none was detected in the blood after the administration of small doses.[3, 14, 15, 16] It was found to be absorbed into the blood when given to patients with achlorhydria.[15] Later, interest in this method of administration was revived when the supply of penicillin became plentiful. Various protectives, antacids, alkalies and buffers were combined with penicillin in a variety of preparations in an effort to protect it from the action of the gastric juice. Numerous articles have appeared expounding the virtues of the particular method investigated. Others were unable to confirm the results of the original investigator while reporting success with a new method. Several workers[6, 17–20] have made a comprehensive study of many of the oral methods of administering penicillin and have concluded that no available method is superior to another. Penicillin dissolved in water gives results essentially as good as those obtained with the use of adjuvants. They have shown that there are several factors involved in the successful oral administration of penicillin. First, destruction of penicillin by gastric juice must be minimized. This purpose can be accomplished by giving doses 5 to 10 times the parenteral dose so that a sufficient amount of penicillin escapes the action of the gastric juice into the duodenum to be absorbed into the blood. The most important factor is absorption through the small bowel. This varies from patient to patient and determines the amount of penicillin found in the blood. To date no method of increasing absorption through the small bowel has been found. Blood levels comparable to those obtained by intramuscular administration have been obtained by direct instillation of penicillin into the duodenum.[3] However, intraduodenal administration is obviously not feasible for general use. The third problem in oral administration of penicillin is destruction by penicillinase produced by certain bacteria present in the large bowel. Cutting et al[20] have shown that penicillin can be absorbed from the colon. This problem would become unimportant if a method facilitating the absorption of penicillin from the small bowel could be found. In any event, no method of eliminating this factor has been advanced.

Loewe and his co-workers[21] found blood levels for 2 to 24 hours following rectal administration of 100,000 units in cocoa butter suppositories in 12 out of 14 patients.

Penicillin has been found in the blood for 1 to 2 hours following inhalation of nebulized solutions of penicillin in doses of 20,000 to 100,000 units.[5, 22–25]

In order to avoid the technical difficulties inherent in the regular parenteral methods of administration, various procedures to delay the absorption of penicillin have been attempted. Administration of penicillin in combination with albumin, gelatin, oils, vasoconstrictor drugs, and the application of cold to the site of the injection have been employed with some success. One of these methods has obtained general acceptance, namely, penicillin in beeswax and peanut oil.[26] This method has been so perfected that adequate blood levels can be obtained for 12 to 24 hours with a single dose of 300,000 units given intramuscularly and subcutaneously.[27, 28] Kirby and his group[29] report that the administration of 600,000 units of the drug in beeswax-peanut-oil mixture will maintain adequate levels for at least 24 hours. These workers have shown that following an intramuscular injection of this preparation, penicillin is found promptly in the blood, and there is no peak level, but instead a prolonged, slowly decreasing concentration is maintained.

Struble and Bellows[30] and others[31] have demonstrated that penicillin will pass readily into all the tissues of the body except the lens, pancreatic juice and gastric juice when administered parenterally. Large doses are required before absorption occurs into avascular tissues such as bone and nervous tissue. Penicillin is apparently concentrated in the liver, since it is found in the bile in concentrations 3 to 5 times that of the blood.[32] Edema fluid has been found to contain significant concentrations of penicillin after intramuscular injection.[2] That penicillin passes through the placenta into the amniotic fluid and fetal circulation has been reported by several groups of investigators.[7, 33, 34, 35] The fetal blood concentration varied considerably and up to two thirds of the maternal blood level. The local application of penicillin to the eye has resulted in absorption of the drug into all the structures of the eye except the lens.[30, 36]

Absorption of penicillin into the various serous cavities has received extensive study. The literature concerning the exchange of penicillin between the blood and spinal fluid appears controversial. It is accepted that penicillin does not merely diffuse into the spinal fluid, as in other serous cavities, but is excreted through the choroid plexus. With the usual parenteral doses no penicillin is found in the spinal fluid in patients without central nervous system diseases.[5, 7, 14, 27, 37, 38, 39] In the presence of meningitis, absorption of penicillin into the spinal fluid occurs in adequate concentration in some patients.[2, 40–45] Several investigators[46, 47] have reported finding penicillin in the spinal fluid after doses of 300,000 to 500,000 units intramuscularly, while others have reported failure with similar doses, or even in amounts of 1,000,000 units.[48] Recently it has been found that two thirds of a group of patients receiving 10 to 15 million units of penicillin intramuscularly over a 24-hour period had penicillin in their spinal fluid, and the percentage was increased to 100 if the dose was raised to 20 or 25 million units.[49] The work of Dumoff-Stanley et al[50] definitely suggests that the diffusion of penicillin into the spinal fluid is dependent on the parenteral dose and the height and duration of the serum concentration obtained. They demonstrated penicillin to be present in the spinal fluid consistently in patients with or without central nervous system disease when a blood level of 1.25 units per c.c. of serum had been maintained for several hours. Others have shown that penicillin diffuses readily from the lumbar area to the cerebral portion of the central nervous system after lumbar intrathecal injection of the drug,[2, 37, 43] whereas passage is less regular from the cerebral to the lumbar area after ventricular instillation.[2] Adequate concentrations of penicillin are invariably found in the spinal fluid for about 24 hours following the injection of 10,000 to 20,000 units.

Penicillin will consistently pass from the pleural fluid into the blood in significant concentrations if the intrapleural dose is over 40,000 units.[5, 45, 51] Absorption is minimal and irregular with smaller intrapleural doses.[3, 5] Doses of 20,000 to 50,000 units injected into the pleura will maintain adequate levels for 48 hours.[52] Increasing the dose up to 300,000 units does not increase the duration of penicillin in the pleural fluid beyond 72 to 96 hours. Conversely, penicillin will diffuse into the pleural spaces when given systemically. Cooke and Goldring[2] have stated that pleural levels approximate the serum concentrations. However, such excellent results are not reported by all investigators.[53–57] The presence or absence of pleural infection does not influence the transfer of penicillin. Similarly, it has been shown that penicillin will diffuse across the pericardial[5, 45] and peritoneal[2, 5, 45, 58] membranes, with the results essentially the same as with pleural membranes. Several investigators[5, 7, 45, 59, 60] have reported that penicillin will pass into the synovial fluid when given parenterally. Herrell et al[7] reported joint fluid concentrations of penicillin up to 50 per cent of the serum levels. In a series of 37 cases Hirsh, Feffer and O'Neil[60] had similar experiences. Others[3, 45, 51] as well as we have found that penicillin will diffuse from the joint into the blood when given parenterally. Although the blood levels are usually significant, they are not always adequate therapeutically, and we cannot agree with the suggestion[61] that intra-articular injection of large doses of penicillin could serve as a method for maintaining prolonged serum penicillin levels. The diffusion of penicillin across the synovial membrane is independent of the dose, serum or joint level, presence or type of joint disease, or duration of treatment. The duration of penicillin in joint fluid depends on the intra-articular dose; 30,000 to 50,000 units maintains an adequate level for 24 hours, 60,000 units for 48 hours, 100,000 units for 72 hours, and 200,000 units for 96 hours. Ory and his co-workers[5] have summarized the results of the transfer of penicillin between blood and serous cavities by stating that although adequate exchange occurs, generally the transfer is erratic, variable and undependable for therapeutic purposes. The diffusion of penicillin from serous cavities into the blood is decreased when combined parenteral therapy is given.[2]

Penicillin is excreted almost entirely by the kidney tubules.[10] Following an intramuscular or intravenous dose 37 to 99 per cent, average about 66 per cent, is excreted in the urine, with the greatest amount found in the urine within the first hour after injection. Rantz and Kirby[10] have shown that the urinary excretion is directly proportional to the blood concentration. Lesser amounts of penicillin are recovered in the urine when the drug is administered by other routes, subcutaneously, about 35 per cent, orally, up to about 30 per cent, intraduodenally, about 23 per cent, rectally, 12 per cent, after inhalations, 10 to 20 per cent. What happens to the drug that is not excreted is not known except that it is apparently destroyed in the body. Free et al[18] expressed the opinion that some of this destruction occurred in the liver, but Cutting and his associates[20] have shown that there is no difference in the excretion when the drug is given into an ear or portal vein of an animal.

Several investigators[62–65] have been able to alter the excretion of penicillin by administering simultaneously other drugs which are excreted by the kidney tubules: diodrast, phenol red, hippuran, para-aminohippuric acid, and benzoic acid. Peculiarly these drugs are excreted in preference to penicillin, so that the serum concentration is elevated, the excretion delayed, and the amount excreted decreased. Rammelkamp and Bradley[62] depressed urinary excretion from 57 to 32 per cent with the simultaneous intravenous administration of penicillin and diodrast. The concentration of penicillin in the blood has been increased 3- to 6-fold by one group of investigators[64] with the maintenance of a blood level of 10 mg. per cent of para-aminohippuric acid, while another group[63] reported elevations of blood penicillin concentrations 2½- to 4-fold with a blood concentration of 30 mg. per cent of para-aminohippuric acid. Both drugs were given intravenously. Bronfenbrenner and Favour[65] reported that the simultaneous oral administration of 2.5 grams of benzoic acid every 4 hours and parenteral penicillin increased the blood level of penicillin 4 to 8 times. It has been shown that high caloric, fluid and salt intake decreases the absorption and hastens the excretion of penicillin. In renal failure the absorption and excretion of penicillin parallels that seen with the use of the "excretory blockade" drugs.

The various authors[27, 28] who have employed penicillin in beeswax and peanut-oil mixtures report that although concentrations in the blood are found for only 24 hours following a dose of 300,000 units, significant concentrations are found in the urine for 3 to 4 days.

Penicillin X, another fraction obtained from cultures of the mold *Penicillium notatum*, has been investigated and the serum concentrations found slightly higher and its excretion somewhat prolonged when compared with an equivalent dose of commercial penicillin.[4, 66, 67] These differences have not been found in comparing commercial and crystalline preparations of penicillin.

The absorption, distribution and excretion of penicillin vary considerably from person to person and even in the same person at different times.

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INAPPROPRIATE TREATMENT OF MOLES PREDISPOSING TO MELANOTIC MALIGNANCIES

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THE tragic onrush of malignant melanoma, the rapidity of its course, and the helplessness of our efforts to control it are forcefully brought to our attention. Most physicians are familiar with these fatal aspects of the disease. Less are familiar with other characteristics of the disease. Within the past few months we have had 3 cases of malignant melanomas. These have followed the electrodesiccation of moles believed to be innocent growths. We present these cases to reëmphasize the danger and tragic consequences which may follow the destruction of moles by heat, electrodesiccation, inadequate cauterization, and the use of chemicals, caustics, carbon dioxide snow, pastes, acids and the like.

Boyd[1] states that benign and malignant moles may be indistinguishable on gross inspection in situ and that many innocuous-appearing lesions may simulate or may be malignant melanomas. There are two forms of pigmented tumors, the one innocent, the other malignant. The former is known as a benign melanoma or a pigmented nevus, the latter as a malignant melanoma or a melanotic sarcoma (melano-epithelioma, melanosarcoma, melanocarcinoma).

Ewing[2] says that the pigmented mole or nevus which is the source of continuous melanomas appears as a minute pigmented spot or soft, flat elevation and often grows to a warty excrescence or papillary tumor. Many exhibit a growth of soft or coarse hair. The color may be light brown to black, or the nevus may be pigment-free. The consistency is usually soft, but eventually the nevus may become hard. The structure varies in different stages.

A survey of the literature on this subject may leave one confused about terminology. We find that the nevus has been thought to be of mesodermal origin. A malignancy developing from it was called a sarcoma and was referred to as a melanotic sarcoma in the older literature. Now many accept the concept that the cells are neuroepithelial cells, and malignant tumor developing from them would thus be called a melanotic carcinoma. In order to avoid a decision as to the origin of the cells, some have adopted the term melanoma, which merely means black tumor (the Greek word mealas meaning black and oma meaning tumor). Again many believe that a mole is a conglomeration or malformation of neuroepithelial cells. The neuroepithelial cells come down to form an end organ, but instead they become grouped into a nest called a mole. These neuroepithelial cells are melanoblasts which can and have the ability to produce melanin. If they do produce melanin the lesion is a pigmented mole, and if they do not, it is a nonpigmented mole. The malignant neoplasm developing from this origin may or may not be pigmented depending on whether or not the melanoblasts produce melanin. Malignant changes supervene spontaneously or after trauma or incomplete extirpation. The apparently innocent histologic character of certain moles which have given rise to secondary tumors is one of the mysterious features of this disease, but, as a rule, the dangerous lesions give gross and microscopic evidence of active growth and especially of increased vascularity. Bickel et al[3] add to the foregoing statements that metastatic lesions as well as primary lesions may or may not be pigmented.

In the 3 cases to be reported, the moles on the face and neck were removed by electrodesiccation. The patients were interested in the best ccsmetic results, and from the small, almost imperceptible scars one might assume that the physicians were likewise concerned primarily with that end.

Webster, Stevenson and Stout[4] reported that in a series of 162 cases of malignant melanomas of skin there were 65.4 per cent with evidence that a mole preceded the development of the malignant melanomas, and that 24 per cent of these malignant melanomas or the moles which preceded them were known to have received improper and inadequate treatment by a physician. Bickel, Meyerding and Broders[3] reported that in a series of 155 cases of malignant melanomas the type of primary lesion was described variously by the patients, 40 stating that the original lesion was a "mole," 25 noting the appearance of a tumor first and 20 describing a "black, brown or purple spot." A malignant melanoma of the skin may appear on any part of the body surface. Bickel and the others state that there is a predilection for the lower extremities and the upper extremities in that order. They may occur at any age and are slightly more frequent in the females. Driver and MacVicar[5] found that 80 per cent (48 cases) of malignant melanomas had a history of a previously existing pigmented lesion. Wilbur and Hartman[6] have found malignant melanomas to arise in several different organs of the body. The most common site is the pigmented mole of the skin, and following this in order are the pigmented areas of the eyes, the anus, and the suprarenal glands. Malignant melanomas arising within the pigmented nevus comprise the majority of such tumors.

The extension of these tumors may occur in three ways, by direct extension, through lymphatic vessels, and by means of the blood stream. Ewing[2] stated that when extension of melanomas is by lymphatic vessels the regional nodes are involved and generalization is relatively slow; repeated local extirpation may accomplish a cure or delay fatal termination.

Moles may remain quiescent or they may become malignant either spontaneously or when activated by stimulation. Melano-epitheliomas may be present for long periods of time before the seriousness of their nature is determined or recognized, and their condition may be activated by meddlesome treatment. Many pigmented tumors or processes in the skin require microscopic study. Any pigmented lesion of the skin should be regarded with suspicion and should be watched.

It is of prime importance, according to Boyd,[1] to recognize signs indicating that a mole is changing into a malignant melanoma. These are a sudden increase in size and vascularity, darkening in color, superficial ulceration, and bleeding. Flat lesions may become raised and indurated, or daughter lesions may develop in or on the edge of the nevus with radiating projections of pigment in the surrounding skin, indicating local dissemination.[5] These are the danger signs as well as the indications for excision.

Blair et al[7] add that the mole that appears at any time during life and progresses in size is the type that most commonly becomes malignant.

It is pertinent to this problem to insist that moles, situated in places subject to irritation, be excised before they show any signs of wildness. Lesions on the feet and nail bed should always be viewed with suspicion. Removal of a mole by any means after evidence of metastasis will not materially affect the case. As expressed by Boyd, it is the widespread metastasis which constitutes the lethal factor. Although it is difficult to diagnose the melanotic melanoma clinically, it should not be difficult to recognize the signs indicating that an innocent lesion is no longer quiescent and that it must be dealt with as a malignancy, regard being given to the fact that the time factor is more important in dealing with melanoma than with any other malignancy.

Prevention is all-important in dealing with this highly serious disease wherein there is a high percentage of malignant melanomas beginning in pigmented moles. The treatment of both nonmalignant lesions and those that are malignant or may become malignant is complete extirpation of the entire lesion. Yet one could not excise all moles, nor would it be reasonable to attempt to remove all moles. The difficulty comes in selecting precancerous lesions for destruction. In general we may say that any lesion subject to irritation from clothing, shaving, braces, trusses, scratching, combing hair, sun rays and the like should be removed. Smooth, coal black nevi and other dangerous pigmented marks should be removed prophylactically. DeCholnoky[8] advises surgical removal of pigmented moles on the feet and irritated areas. Butterworth and Klauder[9] remove all pigmented lesions of the skin on the head and feet, adding that it is dangerous to use procedures which constitute irritation which affords opportunity for malignant change. In a study of 60 cases of cutaneous melanomas, Driver and MacVicar[5] found the great majority of cutaneous melanomas arise from pigmented junction type nevi in the skin. In color these nevi vary from slate blue to bluish black or various shades of brown to jet black. The precancerous lesions are usually smooth and flat, but occasionally they may be raised with verrucous or wrinkled surface; they are nearly always soft. They should be excised. Wilbur and Hartman[6] state that the occurrence of bleeding, growth, color changes, increased vascularity, deepening and spreading of pigmentation, chronic infection, ulceration or crusting of a pigmented nevus should all be taken as a warning of serious proportions and should be followed by immediate excision.

The treatment of choice is a wide, deep, radical excision of the lesion with a sufficiently wide margin of normal tissue and subcutaneous tissue about it before there is any suspicion of real activity. Microscopic examination of the tissue is always made. All of the lesion must be excised the first time. Wide excision may include the removal of regional lymph nodes. Bickel et al[3] add that a biopsy is inadvisable because such a procedure may cause spread of the malignant cells. Electrocauterization and desiccation and the like are inadvisable because they may act as an irritant or stimulant. Just as many malignant lesions have developed as a result of daily irritation, so can cancer follow follow improper therapy which is irritative rather than thorough.[7]

The objection to electric cauterization is that the tissue is destroyed and there is no opportunity for a microscopic examination. One is not certain what he is dealing with. If cauterization or electrodesiccation is used it must likewise be sufficiently radical to destroy the entire lesion. In such an event the wound would be large, slow to heal, open to secondary infection, and apt to leave an unsightly scar. If the cauterization is done lightly to obtain good cosmetic results, there is the ever-present danger of lighting up a malignancy by way of irritation and stimulation. If there had been slight growth or other evidence of activity of the pigmented nevus, the danger of treatment other than by excision is enhanced. Evidence of activity and changes in the mole justify a guarded prognosis as to the occurrence of metastasis, whether the growing nevus was removed by cauterization or excision.

The malignant melanoma is radio-resistant. In general, it is felt that these tumors are comparatively resistant to radium and roentgen therapy.[10] The treatment of malignant melanomas is unsatisfactory.[6] They show practically no response to any type of irradiation therapy. Wheelock[11] reported 2 cases of nonepithelial tumor of the bladder in which radiation gave poor results. Farrell[12] expressed it well by saying that although melanomas are notoriously resistant to roentgen rays, the outlook in late cases of melanoma is very poor in any event and rather than subject the patient to radical surgical procedures it would probably be better to give intensive roentgenologic treatment as a palliative measure. If metastasis is dicovered early and only a few discrete lymph nodes are evident, excision is the method of choice, followed by massive doses of roentgen rays to the involved region.

Coley and Hoguet[13] report the average duration of life in 28 patients with melanotic malignancies to be 2 years and 8 months. Butterworth et al[9] state that generalized metastasis occurs in an average of 3 years.

Report of Cases

Case 1.—P. R., a 17-year-old girl, was referred to us with a tumor of the parotid gland about 1 cm. in diameter, which was moderately hard and tender and without discoloration. It was first noticed by the patient about 10 weeks prior to her original visit. Her skin was clear and fair. No history of moles was elicited. Her physical examination was otherwise negative. A clinical diagnosis of mixed tumor of the parotid gland was made. Under general anesthesia the tumor was excised intact in its entirety with a margin of normal tissue about it. The microscopic diagnosis was melanotic sarcoma. Rechecking her history revealed that she had a pigmented mole on her forehead, which had been removed by electrodesiccation about 6 months previously. The scar was almost imperceptible, and the girl had already forgotten about it. Within 3 weeks after the excision of the parotid tumor there was a small growth noticed in the left upper cervical gland. She was taken to surgery immediately and the left cervical gland region was widely excised. The proximal glands showed the melanosarcoma. The distal glands were negative. A roentgen-ray examination of the chest was essentially negative. Within another week the metastasis had returned to the left parotid region. A wide radical extirpation left her with a partial left facial paralysis. Roentgen therapy (2,016 R's) were given to the left parotid region and left cervical region. The week following roentgen-ray therapy she developed bilateral breast metastasis. These metastatic nodules were widely excised immediately. The pathologic diagnosis was malignant melanoma. The girl continued to go downhill, slipped into coma, and died approximately 9 months after the mole had been desiccated.

Case 2.—P. J., a 49-year-old white female, presented herself with a history of having developed a lump below the right ear lobe 5 weeks prior to her original visit. This lump was red, tender and about 1 cm. in diameter. It was diagnosed as a parotid abscess at a Service dispensary. When the lump did not respond to treatment the diagnosis was changed to mixed tumor of the parotid gland. She gave a history of having a pigmented mole removed by electrodesiccation from the right supraclavicular region about 1 year previously. Examination revealed a hard, hyperpigmented, nodular, slightly fixed tumor about 1 cm. in diameter just beneath the lobe of the right ear at the angle of the mandible. Clinically a diagnosis of melanotic sarcoma was made. There was no lymphadenopathy. A roentgenogram of the chest was negative. Under general anesthesia the tumor was excised intact with a cuff of normal tissue. The microscopic examination revealed a melanotic sarcoma. Following excision of the tumor roentgen therapy (2,500 R's) was given to the right lateral cervical region. The patient is an intelligent woman and became very nervous about the tumor and the tell-tale sequence of treatment.

On May 27, five months after excision and diagnosis, we noted a small, freely movable gland in the right lateral supraclavicular region. This gland, about 1 cm. in diameter, was hard, not discolored, not tender, but growing relatively rapidly. Roentgen-ray examinations taken the following day for evidence of metastases were negative. A very radical dissection of the right side of the neck was carried out on June 1. Pathologic examination revealed melanotic sarcoma. The patient has recovered from the operation with residual areas of paresthesia and disturbances of function of some facial muscles. Her prognosis is now definitely grave.

Case 3.—S. M., a 71-year-old white female, developed infrequent bleeding from an elevated pigmented mole on her forehead. She had developed a habit of scratching this mole during recent years. Paste and silver nitrate did not prevent the mole from bleeding. Three months after the onset of bleeding the lesion was lightly electrodesiccated by her doctor. Subsequently she developed dark, pigmented skin lesions much too extensive for excision. Generalized metastasis developed rapidly, and the patient died within 1 year of her first symptom. This patient was not seen in time to effect any appropriate treatment.

A fourth case is added to illustrate that tumors may be undergoing transformation from the benign to malignant without much evident gross change. Irritative treatment may hurry the transition to malignancy, whereas radical excision may prevent it.

Case 4.—G. T., a 30-year-old white male, possessed a black mole on his right foot, dorsal lateral aspect, about 4 cm. proximal to the fifth toe. The mole was slightly raised and about 1 cm. in diameter. He possessed this mole for several years and had not observed any signs of its activity other than a deepening of its color during the previous few months. A prophylactic radical excision of this dangerous mole was advised and executed. The microscopic analysis revealed the lesion to be a fibromatous nevus, highly vascularized, with manifestations of chronic irritation, increased vascularity and pigmentation and no evidence of any true malignant change. Lesions of this type, if inadequately treated with irritative procedures, may become malignant. Radical removal offers the best prevention. Under any circumstance the lesion bears careful watching.

Summary

In a high percentage of cases the pigmented mole precedes the development of malignant melanomas. These moles are more frequently found on the head and feet.

Moles subject to irritation by clothing, shaving, combing hair, or inappropriate treatment with heat, caustics and the like may and frequently do undergo transition to malignancy because of this irritation and stimulation.

Moles showing activity such as increased pigmentation, vascularity, bleeding, ulceration and growth should be radically excised. Once metastasis has occurred the prognosis is grave, regardless of treatment.

Roentgen-ray therapy holds little hope at present and still is questionable in the treatment of malignant melanomas.

Three cases are reported in which malignant melanomas followed electrodesiccation of moles on the head and neck. Two cases ended fatally. Hope of reducing the high mortality of malignant melanomas lies in early diagnosis of moles undergoing change and thorough excision of the primary lesion before dissemination takes place.

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THE PSYCHOSOMATIC HISTORY

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THE psychosomatic approach to diagnostic problems is nothing new. It was the approach of the old family doctor. He was able to utilize the knowledge which he acquired by his frequent and intimate contacts with his patients to obtain the type of historical data which is such an essential part of the psychosomatic anamnesis. His patients grew up, loved, married, and died under his watchful eye; what he himself missed was retailed to him over the dinner table by his ubiquitous wife. When medical practice became more specialized and the pathologic basis of disease became better known, the intimate facts of the personal lives of patients became of less interest to the doctor and greater stress was laid on the mechanical means of diagnosis; and although the history was by no means neglected, it was evaluated strictly for its significance in terms of organic pathology. The past history was important only for the medical facts it contained. Little attention was paid to the patient's loves and hates, his family problems, his financial stresses, or his fears and anxieties. The clinician was then, as he is too frequently still, impatient over these "irrelevant details."

In the "mechanical stage" of medicine every effort was made to explain the symptoms on an organic basis. The doctor always feared, when his tests did not reveal the organic pathology which he was seeking, "that he was missing something." There was then, as there is now, a tendency to diagnose a functional disturbance by the exclusion of organic disease. This is impossible usually because one cannot exclude every possible organic disturbance by the diagnostic procedures which are at present available.

A new orientation toward functional disturbances is necessary. Too many physicians feel incapable of handling "neurotic" patients, and many others are inclined to treat their problems as "imaginary." They tell the patient there is nothing wrong with him and to go home and forget it. To the patient, as it is to anyone else who understands psychogenic disorders, this is rather silly advice, because he knows that he is suffering and that such suffering is not of his imagination, even if the doctor cannot find the cause of his symptoms. Every patient has a psychogenic element to his illness, even those who have what are, in a strict sense, physical or organic illnesses. This is due to their fears concerning the outcome of their illness and the feeling of insecurity which it engenders. About one third of the patients who seek treatment have psychogenic disturbances for which there is no organic pathology, although there may be a disturbed physiology. Another one third have some underlying pathology, but have also a marked psychogenic component. In this group might be placed a large group of diseases usually thought of as organic, such as essential hypertension, asthma, ulcerative colitis and migraine, in which psychogenic factors play a large role, not only in etiology but also in treatment. The remaining one third are the group of patients mentioned above in whom organic disease is present and definite, but in whom fear and insecurity produce symptoms of their own.

There is nothing new in the psychosomatic approach to disease. As a matter of fact, it is a return to the day when the doctor was a friend in a real sense to his patients. The psychosomatic approach is not usually the psychiatric approach. The psychosomatically-minded physician is interested in those environmental influences which are likely to have produced his patient's symptoms. The psychiatrist goes further than this and seeks the motivating forces and underlying psychopathology. One does not have to be a psychiatrist to practice psychosomatic medicine. Every practicing physician should be interested in it.

The ordinary medical history is deficient in many ways. From the psychosomatic standpoint it gives only half of the picture. It tells what has happened to the patient in a medical way, but from the psychosomatic viewpoint it is necessary to know what environmental influences were working on the patient while he was experiencing his symptoms. The following is a good example of this:

The chief complaints were weakness, epigastric pain, and excessive "gas." In May of 1945 the patient had a "virus" infection of the throat and subsequently developed whooping-cough. The constant cough caused her much distress and general debilitation. She recovered from the pertussis, but her general condition did not return to normal. In subsequent weeks she developed numerous pains, chief among which was an epigastric discomfort or pain which occurred rather constantly, particularly a short time after meals and which she described as "indigestion." The pain was not sharp but aching in character and radiated along the right costal margin and to the back; it also occasionally radiated to the right breast. This had been diagnosed as gallbladder colic, and surgery had been advised in spite of negative X-ray findings. She belched frequently and expelled gas. At times she had vague pains in her lower abdomen and a feeling of "tightness." Her bowels moved only with the aid of laxatives and she had a bowel movement only with considerable difficulty. Her appetite waned and she was eating chiefly bland foods. Foods which disagreed with her included fats, pork, cream, ice cream, cabbage and sweets. Eating these foods promoted the abdominal manifestations described above. Her eating habits were regular, but she believed her intake was not adequate. In the past few weeks she had experienced a burning or "stinging" sensation on urination and stated that she was incontinent at times. An examination of her urine at one time recently revealed "blood and pus"; but a repeat examination was negative. She described intermittent lumbar and low pelvic pain and stated that her "kidneys have been weak lately." On some occasions she had a feeling of oppression in the vicinity of her heart, not promoted by exercise. She had periodic episodes of coughing and a "dry sensation" in her throat. Generalized muscular pains had been present lately contributing to her general debility.

She stated that she had felt considerably better in the past 24 to 36 hours. The day before she felt nauseated and ill and had a peculiar pain in her back. She drank a considerable quantity of water, then experienced a "sort of snapping sensation" in her back, after which she felt much better, and a relative stated that she looked better.

She had had the usual childhood diseases and no major illnesses. She was in an auto accident many years ago receiving multiple injuries, chiefly involving the right side. Five years ago she was operated on for removal of a fibroid uterus and chronically inflamed appendix.

The physical examination was essentially negative except for hyperesthesia of the breasts, chiefly the right, with tenderness elicited on palpation. There was a moderately firm, irregular mass palpable in the inner aspect of the right breast, which was not clearly defined and might represent breast tissue with fibrosis. The left breast was relatively non-tender, and no masses were palpable. There was no bleeding or discharge from the nipple. The abdomen was free of masses. There was tenderness 1+ in the epigastrium and right upper quadrant. The liver was not palpable, nor was the spleen.

This history written by the resident is a good example of the facts usually elicited by the medical history. The environmental history in this case established a new viewpoint and cast new light on the nature of the patient's symptoms. The patient with slight encouragement gave the following additional history:

She had been very unhappy about coming to this country, which she did at the age of 10 years. This, however, seemed to have little to do with her symptoms, because as far back as she could remember she had reacted to emotional disturbances by gastrointestinal symptoms. It had always been her ambition to be a singer, and when she was about 20 years old she began to take singing lessions from a woman teacher, "who was rather eccentric, she insisted on putting her arms around me and handling me while she was teaching." Her experience with this homosexual instructor finally became unbearable, and she gave up her lessons, but only after marked conflict, because she felt that in doing so she was renouncing her career. At a somewhat later period she fell in love with a chronic alcoholic, with whom, in spite of a very strict religious conscience, she had sexual relations in an effort to reform him. This effort failed after several years and she gave up this man, having as the only consequence a severe self-criticism. Some time later she fell in love again, this time with a man whom she had met at a party and who displayed interest in her. Her advancing years made attention desirable, inasmuch as she had always retained the desire to get married. This man was insistent on sexual relations to which she again consented, although reluctantly. Again her rigid conscience began to plague her and she soon broke off the relationship. Her feelings of guilt in this instance were more severe, and she developed in addition to her digestive disturbances (which resulted in hospitalization) many prepsychotic manifestations. Among these she expressed ideas of influence. "He had a hypnotic power, he was able to put his thoughts into my mind and I was unable to help myself." She also expressed ideas of reference. "He told everybody about me, people used to turn and look at me, he would be everywhere."

After a thorough work-up as a result of which no organic pathology was discovered, the patient was given psychotherapy and is now, at least temporarily, free of her symptoms and has good insight.

Looking deeper into the environmental factors and into the personality of the patient pays dividends not only for the doctor who thus will make better and more accurate diagnoses, but also for the patient who will be spared many unnecessary surgical procedures. The process is undoubtedly time-consuming and does not adapt itself well to the routine of the busy practitioner, who must see large numbers of patients in a short time. He could, however, have those patients who present atypical pictures or in whom he suspects a psychogenic disorder return at a time when it is more convenient and he is not rushed. If this is not possible, he should refer this type of patient to somebody else who has more time and more interest in psychosomatic medicine. Too frequently the doctor is satisfied when he asks the question, "What is worrying you?" and feels that thereby he is doing justice to the emotional side of his patient.

For those who ask for a systematic approach to the psychosomatic history a definite answer is very difficult. There is no brief, quick question-and-answer form. By changing the focus somewhat in the ordinary medical history much useful information may be obtained. The ordinary focus is on symptoms; the psychosomatic focus should be on environmental influences which were affecting him while he was having his symptoms. If this is borne in mind while the ordinary form of the medical history is being used, an entirely different result may be obtained. "The greater our success in switching the conversation from symptoms to personal affairs, the sooner do we come into possession of the real problems disturbing the patient."[1] In taking the family history, it is not sufficient to inquire into the causes of death of the father and mother, the grandparents and others. It is important to ask whether or not anyone else in the family had symptoms like theirs; do they resemble one or the other of their parents; how many siblings have they? If their parents are dead, were they with them during their last illness; did they nurse them; did they have to watch the suffering of their loved ones? Ask about interfamily relationships; did they get along well with their parents and siblings? There are many other questions in regard to family relationship which would be suggested by answers to the above and which would give valuable clues to the personality of the patient and probably explain many of his symptoms.

In the past history the changed psychosomatic focus will skip quickly over the usually elicited medical facts and inquire again into the circumstances behind these events. The following is an interesting case from this standpoint:

This patient was a white female, 26 years of age, who was referred for study because she had several severe attacks of right-sided abdominal pain. The past history was taken in the usual manner and revealed only that she had had several previous attacks of right-sided pain and on one occasion following a cystoscopy, a diagnosis of ureteral calculus was made. She had been discharged from the Waves because of frequent spells of fainting. If the physician had been satisfied with this usual type of history, he would undoubtedly have been satisfied that the trouble was urinary in origin. A psychosomatic history, however, which is too lengthy to be quoted in its entirety, revealed among other things that she was an only child of parents who were constantly at words with each other, that her mother was a cardiac invalid for a great many years and the patient was required to constantly attend her, that from early childhood she had had a marked tendency toward kleptomania and pathologic lying, and that at the age of 15 it was her father's custom to send her to the bank once a week with money to pay off a loan. She regularly appropriated this money for her own use and when the bank began to send notices of nonpayment, she went to the president of the bank and told him the truth about taking the money, but stated that she had used it to help out one of her friends who was illegitimately pregnant. Upon receiving the promise of the bank president that he would give her a month to pay back the money, she secured the requested amount from a variety of boy friends. She was brought up as a Catholic, but in spite of the fact that she was supposed to fast before going to Communion, she made a regular practice of eating breakfast. She had no explanation for doing this so regularly except that she thought it was fun to fool the Sisters. She developed the practice early in life of becoming sick or fainting whenever she did not get her own way. In this way she tended to identify herself with her mother who had her worst heart spells when her husband would start an argument. This practice of fainting continued with increasing frequency, and after entry into the Waves it was employed with such frequency that she was finally admitted to the hospital and discharged medically because of them. At the insistence of her father she married a man somewhat older than herself with whom she did not make a good adjustment, and during his absence at work she conducted a number of love affairs with other men. After divorcing her husband she accepted employment in a government bureau, but after a year she was asked to resign because of her promiscuity with the male employees. According to her own statement, she spent each weekend with a different man. After leaving this employment she entered the Waves and thereafter continued to spend each weekend with a different man. During this entire promiscuous period she was sexually frigid in her heterosexual relations, but continued to masturbate at quite frequent intervals. During this period she also had a number of homosexual fantasies. During her period in the Navy she fell in love with a junior officer who would not marry her at first, but she insisted on a trial period of 6 months, "so I could make him love me." She thereafter married this officer and began to be plagued with feelings of guilt concerning her past. During this period, in spite of her frequent heterosexual relations, she continued to masturbate at very frequent intervals.

There are other factors which might be brought out in regard to the environmental influences playing a part in this case, but the above will provide a fairly good example. It may be that her present symptoms were precipitated by the fact that she had discovered that some of her husband's friends were among her previous sexual companions and she was afraid that they would reveal these facts to him. In this case, as a result of psychotherapy, which stressed the development of more mature attitudes, the patient has improved considerably and has been symptom-free for over 3 months.

The other facts in the past history of importance are difficult to enumerate, but if a systematic review is made of the environmental influences affecting the individual during childhood, school life, employment, and his marital and sexual life, important factors will be obtained. Many doctors feel that patients resent questions in regard to the intimate details of their personal lives. This will not be the case if he will take time and show the patient that he is interested in him as a person and that he is desirous of helping him in more ways than merely treating his symptoms. Many patients, after having been passed from one doctor to another with little help except to be told that there is nothing wrong with them, when given the opportunity will spontaneously reveal the cause of their symptoms. "I've never told any other doctor about this, they always seem to be in such a hurry and I didn't think it was important."

A great many psychosomatic difficulties arise over misunderstanding and ignorance in regard to sexual matters. There are many doctors who feel too much stress is laid on sex. I have no doubt that in certain quarters this is true; nevertheless, sexual conflicts do play an important role in the genesis of functional disturbances. A new attitude and a new approach on the part of the physician are necessary if he is going to help the patient overcome these difficulties. Too many doctors shy away from a discussion of sex with their patients. This is very frequently due to their own ignorance of these matters and a feeling that the patient is reluctant to discuss them, a feeling which I have found without merit. The patient needs little encouragement and he will be grateful for the opportunity of discussing his sexual life with one who he thinks can help him. There is no special technic for eliciting these facts. Too blunt an approach will usually arouse a defensive attitude on the part of the patient. In women, a discussion of the menstrual history may be followed quite naturally by questions in regard to frigidity and then into more intimate details. In men, in whom these difficulties are more frequent than we realize, bluntness is especially contraindicated because their male egotism makes any remark which sounds like criticism of their sexual ability a matter of insult.

Overenthusiasm in regard to psychic difficulties may lead the clinician astray. A very good background for psychosomatic disturbances may keep the diagnostician from seeking further into the organic factors.

A white female, 49 years of age, was admitted to the hospital complaining of pain in the chest. For the past 2 years she had had moderately severe, frequent aching pain in the left chest anteriorly and a sensation of thoracic compression. This symptom was incited by activity such as standing while washing dishes, eating, and walking up steps. The pain was relieved by rest. She quite often woke up at night with attacks of such pain. Dyspnea would accompany the pain, which was of moderate severity. Frequently the pain radiated to her back in the interscapular region. Nocturnal dyspnea was a less frequent but disturbing occurrence. Moderate indigestion characterized by an intolerance for cabbage and meat (particularly liver and steak) was a frequent complaint. This had developed in the last 2 years. Physical examination was essentially negative.

The psychosomatic history revealed that for the past 2 years she had had 2 sons in the service. One of these sons had written regularly and had returned home. The other wrote irregularly and was married while in the service. The patient had not seen her daughter-in-law but had written to her frequently. She had had no answers to her letters and at the present time does not know where her son is. She became overemotional while discussing this matter and was considerably relieved afterwards. "He was such a good boy. It is not like him to act like this." X-ray examination showed a large number of stones in the gall-bladder, leaving for the clinician the decision as to how large a part the psychogenic factors played in the symptomatology. Her response to psychotherapy was so good that it was decided to leave the gall-bladder in place.

In conclusion, it should be again emphasized that there is no routine method of eliciting the psychosomatic history. If the patient is given a chance he will usually tell what is wrong with him. More time spent in history-taking will save many unnecessary procedures. The surgeon cannot remove a pain of psychogenic origin, nor can the roentgenologist see it on his films; only the psychosomatically-minded physician can detect it by his painstaking attention to the details of the history.

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President's Page

"I AM CONFIDENT . . ."

The problems facing us in the coming organization year are diversified but constitute a challenge such as we have seldom been called upon to face.

Prepaid medical care underwritten by our Society is in itself a tremendously vital responsibility which is bound to demand the loyal and unselfish efforts of all our members. You need not be told that the solution of our medico-economic problems calls for a continuous elastic attitude on our part. The groundwork has been laid by a group faithfully and conscientiously working under the able and unselfish guidance of our chairman, Dr. Frank D. Costenbader. Words are inadequate to express our gratitude to this tireless group of our members.

Our interest in community health as evidenced by our Committee on Public Health and its various subcommittees will be intensified through collaboration with the Health Department.

Our scientific programs, which have been of an unusually high caliber, will continue to occupy a large part of the Society's interest. The presence in our community of outstanding scientists associated with the Army, Navy, United States Public Health Service, Department of Agriculture, and faculties of educational institutions, makes available the richest possible source of inspiring scientific presentations for our instruction.

Cancer, degenerative cardiovascular entities and geriatrics will call for and receive much needed attention.

Periodic health examinations should be diligently encouraged and publicized in the interest of community health.

Dissemination of scientific data to the public must be carried on in a constructive and vigorous manner.

Constant legislative vigilance to prevent enactment of acts derogatory to the best public interest along with formulation of constructive legislation of our own will continue to be one of our most valuable public services.

Veterans' health problems, particularly as they relate to our returned medical officer personnel, will call for much effort on our part. We will also take an active interest in the medical care of veterans.

Continuing coöperation with, and assistance to the hospitals, and the dental, nursing and pharmaceutical professions will be very much in the public interest.

The above activities are but a few of the endless list our Society will carry on in 1947. I am confident that when this year's record is complete we will not have been found wanting.

William J Herbst Jr

WILLIAM PARKER HERBST, JR., M.D., M.S., F.A.C.S.

President, The Medical Society of the District of Columbia, 1946–1947

Editorials

WILLIAM PARKER HERBST, JR., M.D., M.S., F.A.C.S.

Dr. William Parker Herbst, Jr., eightieth President of the Medical Society of the District of Columbia, enjoys the distinction of being a native Washingtonian. His father, William Parker Herbst, for a long time conducted a pharmacy at 25th and Pennsylvania Avenue, N.W., which perhaps explains in part, at least, his son's decision to become a physician.

Dr. Herbst was born November 15, 1893. He received his early education in Washington public schools, and his medical education at Georgetown University School of Medicine, from which he graduated in June, 1915. He served internships at Georgetown University and Columbia Hospitals, Washington.

At the outbreak of World War I, Dr. Herbst enlisted in the United States Navy Medical Reserve Corps. He was called to active duty on May 7, 1917, commissioned a Lieutenant (j.g.), and attached to the Grand Fleet. He resigned as Lieutenant on October 1, 1919. Immediately thereafter he accepted a fellowship at the Mayo Clinic where for the next five years he devoted himself energetically to the study of surgery and urology.

He entered private practice in Minneapolis, and in 1926 became a member of the staff of the University of Minnesota Hospital. From the beginning he limited his practice to genitourinary surgery. In 1933 he returned to Washington, where he has since resided.

Many honors have come to Dr. Herbst during his professional career. At one time he was Chairman of the Section on Urology of the American Medical Association. He was President of the Washington Urological Society and for some years was a member of the Executive Board of the Medical Society of the District of Columbia.

Among the professional societies in which he holds membership are the American Medical Association, American College of Surgeons, American Association of Genito-Urinary Surgeons, the Washington Academy of Surgery, and the Minneapolis Surgical Society. He is a diplomate of the American Board of Urology.

For a number of years he was an Associate in Urology at the University of Minnesota School of Medicine. He was Professor of Clinical Urology at Georgetown University School of Medicine from 1935 until early 1946, when he became Professor of Urology.

Like all physicians with an interest in research, he has made many contributions to scientific publications and frequently speaks before national medical societies.

Dr. Herbst married Miss Catherine Meredith Arnold of Chicago, Illinois, June 12, 1920. They have two sons, Dr. William P. Herbst, III, recently graduated from Harvard Medical School and now interning at Boston City Hospital, and Robert Van Courtland Herbst, a student at Princeton University, and one daughter, Mrs. William L. Howell of Washington. Dr. and Mrs. Herbst live at 2425 Foxhall Road, N.W.

Dr. Herbst has been active in the Medical Society for many years. Most members know him or, at least, of him. To his intimates he is a friendly, personable man for whom they have the highest regard. His integrity and deep loyalty to his profession are well known. One is impressed when meeting him for the first time by his quiet courage and straightforwardness.

He is never ruffled. Always the same, he is cheerful under the most trying circumstances. He is a clear thinker, independent in his views, and once convinced of the correctness of his beliefs is not readily swayed.

Dr. Herbst is well aware that his presidency comes at a critical time in medicine. Luckily for the Medical Society, it has in him a man who will certainly give the Society sound and courageous leadership.

LUMBAR SYMPATHECTOMY IN THE TREATMENT OF PERIPHERAL ARTERIOSCLEROSIS

For many years the treatment of arteriosclerosis of the lower extremities was essentially medical. An effort was made to protect the tissues from injury, to which they are particularly susceptible because of the devitalization which results from impairment of blood supply. Attempts were made to encourage the development of a collateral arterial circulation by means of many ingenious medicinal and mechanical devices, some of which may have helped. Surgical procedures were not employed except for some such "conservative" purpose as removal of an extremity in which gangrene, infection, or intractable pain was a threat to life itself.

Limitation of therapy to this kind of program was largely an outgrowth of the concept that the restriction of blood supply in cases of peripheral arteriosclerosis was entirely the result of organic arterial obliteration, that the capacity of the diseased arteries could not be expected to increase, and that eventual improvement must await the gradual enlargement of existing collateral channels.

This organic concept of the pathologic physiology of arteriosclerosis has now been modified to the extent that most investigators agree there is a functional component in the mechanism of diminution of arterial flow. The extent to which the functional component contributes varies considerably, depending upon the degree of arterial constriction originating from sympathetic nerve impulses. In those cases in which functional arterial constriction plays a significant part in the reduction of blood supply, it can be predicted that improvement will result from the abolition of the sympathetic nerve supply. The arteries which are sclerosed but not completely occluded, as well as the normal arteries which comprise the collateral circulation, can be expected to transport more blood when the "tonic" effect of the sympathetic nervous system is removed. At present the popular technic for accomplishing this result is lumbar sympathectomy.

The choice of cases of arteriosclerosis of the lower extremities for lumbar sympathectomy must be made with great discrimination. Instances in which the reduction of blood flow is severe and is largely the result of organic arterial narrowing obviously will not be benefited by this kind of surgery. Indeed, it may do harm by diverting blood from areas in the extremity in which the balance between life and death of tissue is precarious. Atlas,[1] who was one of the earliest advocates of lumbar sympathectomy for the treatment of peripheral arteriosclerosis, emphasized this fact by reporting 3 cases in which sympathectomy promptly induced gangrene.[2] His explanation of this phenomenon was that, "in the presence of a rigidly impaired blood supply, surgically induced relaxation of patent and flexible arteriovenous anastomoses in an ischemic foot could shunt blood from the capillary beds in sufficient quantity to cause tissue necrosis."

In general 2 methods for selection of cases for sympathectomy have been advocated. The first and more widely used consists in an evaluation of the effect on the circulation of inhibition of the sympathetic nerve supply to the affected extremity. This can best be accomplished by blocking the lumbar sympathetic ganglia with 1 per cent procaine solution. When this is done, a prompt, marked rise in temperature of the skin of the toes is probably the best sign of improvement of the arterial circulation. Improvement in walking ability, decrease of the venous filling time, increase in the volume of the arterial pulse as measured with an oscillometer, and other indications of increased arterial flow may also be observed. De Takats and his co-workers[3] mention also that in an occasional case the relief of pain due to severe ischemic neuritis may justify a sympathectomy.

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[1] Atlas, L. N.: Am. Heart J., 1941, **22**, 75.

[2] Atlas, L. N.: Ibid., 1942, **23**, 493.

The second method for case selection depends upon the appraisal of the patient's general "vascular tone." Naide and Sayen[4] believe that the development of a collateral circulation in any case of peripheral arterial obstruction depends mainly upon the vascular tone of the patient. For practical purposes they classify patients in 2 groups of high and low vascular tone. A patient is regarded as having low vascular tone if his hands remain warm (25° C. or above) 15 minutes after he has been in a constant temperature room at 20° C., unclothed except for a light gown. This patient's peripheral vessels are easily relaxed, he tends to develop a collateral circulation readily, and the circulation in his lower extremities will not improve much if at all from a lumbar sympathectomy. On the other hand, a patient whose hands become cool (below 25° C.) under the same environmental conditions has high vascular tone and probably will benefit from, indeed may urgently need, a sympathectomy. Naide and Sayen state that in the group with high vascular tone, patients in whom a rise in skin temperature of the toes does not follow inhibition of the sympathetic nerve supply may nevertheless show improvement after sympathectomy. This finding needs confirmation, especially in view of the fact that these authors used procaine block of the posterior tibial nerve to produce sympathetic inhibition, and this test is not entirely reliable.[5]

The results of treatment of arteriosclerosis of the lower extremities with sympathectomy have been highly encouraging.[1, 3, 6] The method has been truly disappointing only in cases in which the criteria for selection of patients were lax. In properly selected cases, improvement of some kind is the rule. It may take the form of an increase in walking ability, prevention of changes which would necessitate amputation, provision of the opportunity to perform amputations at lower levels, or the relief of otherwise intractable pain.

H. H. H.

NEW AUXILIARY PRESIDENT

MRS. WILLIAM PARKER HERBST, JR.

President, Woman's Auxiliary to the Medical Society of the District of Columbia, 1946–1947

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CAN WE "CONTROL" VENEREAL DISEASE?

Physicians along with sociologists and other scientists as a rule are not inclined to moralize. Rather do they attempt to examine and appraise human frailties and to prescribe the indicated therapy. Oftentimes, however, this prescription involves admonitions regarding habits and conduct such, for example, as those against over- or under-eating, over-exercising, over-excitement emotionally et al. Frequently these warnings and advices deal, of necessity, with sexual habits and exercise, and it is in this field that observers have noted wide shifts in medical views during the past decade. Particularly is this true of views regarding the control of syphilis and gonococcal infections.

More exact and increasingly sensitive laboratory tests have simplified, greatly, the problems of diagnosis. Chemotherapy and the use of antibiotics have made such progress in recent years as to provide for non-infectiousness in a matter almost of a few hours, and arrest or "cure" within a few days. But, despite this marvelous armamentarium of tests and treatment media, the venereal diseases are not being "controlled"; despite the therapeutic miracles of penicillin, the sulfa derivatives, arsenicals, bismuth, and diathermy, and the mounting knowledge of and facility in their uses, the Nation's (and the world's) statistics on the incidence and prevalence of venereal infections show little tendency toward a downward trend. Here in Washington, for example, gonorrhea totals are ascending while those for syphilis mark time, with occasional slight rises or declines.

In essence, then, the "salvaging" process has been vastly improved with no commensurate improvement in the processes of prevention and control. There are, seemingly, as many, or more, new infections and reinfections as in previous eras but their ravages in terms of bodily disability, congenital manifestations and neuropathology are being notably lessened. These results are evidences of real progress and are genuinely gratifying to all humanity. Public health technics of case-finding and case-holding, largely via "shoe-leather epidemiology," have added measurably to the scope and effectiveness of the diagnostic and treatment efforts, but still we are dealing mainly with salvage although a certain degree of prevention does result when infectious cases are promptly sterilized. But, to return again to our main thesis, how can we attain true venereal disease "control"?

The most pertinent and logical answers we have heard to that question were given by two eminent syphilologists, Drs. Joseph Earle Moore and John H. Stokes, in testimony before the House Judiciary Committee on March 18, 1946. Said Moore, after reviewing late developments in penicillin therapy, ". . . it is not possible to control the incidence of venereal disease by the treatment of the infected patient. Additional measures are necessary." Said Stokes, " . . . as medical treatment gets simpler and more effective, venereal disease figures go higher and higher. Clearly treatment alone is not the answer we are looking for despite its medically spectacular achievements. Critical reëxamination of the control problem . . . is showing clearly that the root of the problem lies in casual and promiscuous sexual relations. . . . The moral pressure of the community against promiscuous sexual behavior is what determines the prevalence of the disease."

Other medical and public health leaders concur with these authorities in believing that conduct, not medication, is the keystone to real venereal disease control. Or, as the terse, pungent prose of Hippocrates might phrase it, "Casual and promiscuous sexual behavior are contraindicated."

Having proceeded thus far, your essayist asked one of his medical friends to give the screed a brief "once-over" and appraisal. "Well," asked he, "isn't conduct-training and guidance more properly the province of parents with help from the church and school?" In the main our reply would be "Yes," but on many occasions the advice of a trusted physician can have as much influence as any of the other sources--sometimes more. And the world today can use sound ethicists as never before, in whatever social or professional category they may be found.

RAY H. EVERETT
Executive Secretary, Social Hygiene Society of the District of Columbia

In and Out of Focus

BY THE OBSERVER

Every Year Is Different

As our Society enters upon a new organization year, it is interesting to speculate what is in store for it. Your Observer has seen many administrations come and go. Each to a greater or less degree is different. This year change will be more evident than in the war years for a variety of reasons.

As is customary the Society has a new "skipper." He is a cool, forceful man in the prime of life, qualities which should be reflected in the Society's endeavors.

What promises to be an important factor this year is the return to civilian life of most Washington physicians who served with the armed forces. These men are much more mature than when they left for war and, fortunately, they are keenly interested in their medical organization. This was not overlooked by the incoming President, for he has appointed a considerable number of them to important committees. They are expected to be an influential group in the Society in the coming year.

There are also many new members, most of them veterans who, for one reason or another, have decided to establish themselves in Washington. They are a larger group than is generally realized. In the month of June nearly one hundred were admitted to membership. They, too, will have a decided influence on the Society's affairs.

Another factor which should not be minimized is the effect of international and domestic turmoil on medicine. Developments abroad and at home will have a decided bearing on the Society's accomplishments, and, as a matter of fact, on what happens to medical practice. Of course shifting political and social forces may not become sufficiently crystallized in the near future to result in more than moderate change, but one never knows. At any rate the social upheaval now in progress will in the long run have a far-reaching effect on medicine.

There is no justification for alarm in these circumstances. In fact, present conditions are a challenge to the best in physicians. They hold the opportunity for improving the lot of their patients as well as themselves. All in all, your Observer looks at the immediate future from the standpoint of medicine with confidence providing physicians do not shut their eyes to what is going on around them. He feels certain that in so far as the District of Columbia is concerned, the medical profession will go forward to greater achievements.

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Up to Now

As is well known, most physicians are not particularly well informed where social and economic problems relating to medicine are concerned. In the past this applied equally to officers and members of medical organizations. Presidents elected to serve for only one year were seldom interested nor did they bother to learn what it was all about. They retired from active participation in the organization's affairs at the end of their term and were glad to shed their responsibilities. It appears now that this situation is no longer quite as common.

Your Observer has read many addresses given by Presidents upon their being elected to office in recent months, and he is struck by the fact that there is a growing appreciation of the social responsibilities of organized medicine. Some of them approach the issues gingerly, others diplomatically, and a few courageously. Not many have been so severe on their colleagues as Dr. Andrew E. Amick, President of the West Virginia State Medical Association. In his annual address he said to his fellow members:

> "Up to now we have been disinclined to be realistic, or quite frank in the admission of our failures, more especially in calling attention to those things that made the failures. Our long standing lethargic reaction to the distress of our fellow man in his problem of securing good medical care for himself and his family convinces me that we have been facing down the road to hell, lured by the mirage of personal prosperity and security.
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> "An honest confession, I am told, is usually helpful. In other words, I am frank to say in passing that I have one big regret, namely, that I have given so little to the problems of our Association. Medicine has been good to me, as I am convinced she has been to each of you. What of our reciprocity? In my blissful state of intellectual ignorance, I have the effrontery to point out to you some of the reasons why I think we are missing much well earned immortality. This, I hold, is because up to now we are doing a job just helf well.
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> "In the main, our attitude over the last decade has been: 'We can coast along and win.' True enough, we have been 'coasting,' but you coast downhill. All of us know or should know that we cannot in this manner maintain the 'status quo'—retain our liberty and the right to express our honest views, or fulfill our desire to see the continuation of 'free' medicine in West Virginia and the Nation.
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> "Up to now, we have gone on the assumption that we are superior to other laboring groups. The fact is that the physician by and large differs little from the average human being.
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> "Up to now, we have wasted much time in telling the world how enlightened we are. We point to the progress of our scientific medicine in the last two decades as if this progress implied that the people are not worthy of a voice in the determination of the type of medical care they desire. Since scientific progress doubtless has been just as great in other fields of endeavor, there is no need for our progress to center in our heads.
>
> "Up to now, we have ignored the social implications in our medical progress, its needs and possibilities, its opportunities and dangers.
>
> "The endeavors of an individual, an organization, or a nation have a central idea. If and when this idea becomes exhausted, a crisis results. Here and now we are face to face with such a crisis. For a few decades we have gone on the assumption that the patient exists for the doctor, rather than that the doctor exists for the patient. An organization must be judged by the point from which it starts, the goal which it sets, and the progress which it makes. A self-righteous attitude on our part ignores those realities and creates a gulf of misunderstanding between us and other organizations, between us and the people whom we are supposed to serve. We need not waste more time in pointing to the achievements we have attained in medicine in the last thirty years as if they signified that the people need have no voice in determining the type of medical care they need today. The point at issue is how to bring the social applications of modern medicine in line with scientific progress in eradicating and preventing disease.
>
> "Up to now, our attitude toward preventive medicine and its procedures has been negligible and indifferent."

Dr. Amick pointed out that the physicians who have returned from the armed services appreciate the fact that the status quo can no longer be maintained, "if we are to keep even fragments of free medicine in West Virginia and the Nation." He reminded his listeners that 12,000,000 veterans received excellent medical care and were not too concerned about free choice of doctor or the doctor-patient relationship and that these veterans expect continued good medical care. He proposed that the Association help establish groups, and associate such groups with voluntary prepaid medical and hospital insurance plans.

> "Medical or health centers and rural clinics," he says, "must do the routine treatment and preventive work. Cases requiring more specialized care must be sent to general hospitals.

> "Such a program means that counties, or groups of counties, must assume responsibility for the building and equipping of such centers and clinics, as well as for the fee-for-service rendered their medically indigent.
>
> "Today an informed public is debating the question: Which will give better results, our individualistic concept of medical practice that permits the physician complete freedom to act as he pleases without ever taking the welfare of society as a whole into consideration, or a carefully planned, organized medical service directed not for the individual gain of a few but with the needs of the entire population in mind? The Supreme Court of the United States has held: 'There is sufficient historical evidence of professional inadequacy to justify occasional popular protests. The better educated laity of today questions the adequacy of present day medicine."

These are quite revolutionary views for a medical society president. Many physicians will not agree with them. None can deny that this is the dynamic leadership which organized medicine sadly needs in these days.

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". . . One of the Most Thrilling Developments . . ."

The failure of laymen, especially business and labor leaders, to come to the fore for the medical profession in the present controversy over methods of providing medical service is not readily explained. One would think there would be many champions of the profession in lay groups considering the close relationships of many of them to individual doctors. But the fact is that there have been comparatively few. In this select group are Mr. Roy E. Larsen, President of Time Incorporated, publishers of the weekly news magazine.

Speaking before the Philadelphia County Medical Society on May 9, Mr. Larsen said:

> "That most people want prepaid health insurance there is now no question. We must face up to the fact that there is tremendous interest in the Federal plan, but there is a growing interest in voluntary plans. Two polls of public opinion were recently taken on this subject. The first, completed by Dr. George Gallup's Opinion Research Corporation, showed that a great many people were opposed to governmental medicine—in fact, 76 per cent of those people questioned were opposed to governmental control of the medical profession, and 87 per cent thought that compulsory insurance would not provide a satisfactory solution to the problem of medical care costs. The second poll, taken by the highly reputable National Opinion Research Center at the University of Denver, indicated that 48 per cent of all the people questioned preferred Government compulsory insurance to voluntary prepaid plans—that 68 per cent thought the Social Security law should include Government medical insurance. But the findings of both polls proved conclusively that people do want some form of prepaid insurance, whether it be compulsory governmental or a voluntary private plan. In the Gallup poll 63 per cent wanted an easier method for the payment of medical fees, and 45 per cent thought that prepayment was the proper method to allay this want. In the Denver findings 82 per cent wanted medical payments made easier, and 55 per cent thought that prepayment was the proper method. So the problem boils down then, it seems to me—but perhaps I oversimplify it— to the question of how the American people are going to get their prepaid health insurance."

Mr. Larsen reviewed the history of voluntary insurance plans, the first of which was introduced in Tacoma, Washington, in 1917, followed by a second in Oregon in 1926. "Seven years ago," he said, "there were only 1,500,000 people enrolled in the 40 voluntary health insurance plans existent at that time. What has happened since is one of the most thrilling developments in this country and a great tribute to the men of medicine and to voluntary hospitals who have accomplished it."

The Blue Cross Plan, he observed, has enrolled more people in a shorter time than any voluntary program in the history of the world. In approximately ten years, the Blue Cross enrolled 20,000,000 members. More than 3,000,000 people are now covered by private medical care insurance, and another 11,000,000 are protected by group policies in commercial companies, coöperative plans, and by other means, making a grand total of over 30,000,000 people covered by some form of voluntary health insurance.

He related that in Rhode Island 53 per cent of the population is now enrolled in Blue Cross. In Massachusetts a year ago, one of every six people was protected by private hospital insurance. In the western part of Pennsylvania there has been a vast increase in Blue Cross membership. "Such records," he said, "challenge Senator Murray's statement that 'volunteer plans just won't meet the need.'" He admitted that there are "bugs" in the machinery of voluntary prepaid medical insurance plans but believes that they will be eliminated as experience is gained with them; also that they can be coördinated on a nationwide basis.

> "It is my personal belief—based on the record of those states and communities which have really done a job of selling their voluntary insurance plans—that 80 million people can be reached and covered by them. Take 55 million employees—or Mr. Wallace's 60 million—add their families—and you have a potential for voluntary health insurance plans in excess of 80 millions of people. With such an enrollment, there could be no argument for state or Federal health insurance."

Mr. Larsen emphasized that too few people know about voluntary plans and he urged that a better publicity program be inaugurated.

> "I, for one," said Mr. Larsen, "would like to see more publicity put out by doctors and voluntary insurance plans to spread the available information concerning their achievements to every corner of the land. I have the courage to suggest this break with traditional ethics in the medical field because, in western Pennsylvania and in Massachusetts, for example, the job of informing the public is being done through paid advertising in the daily newspapers, on car cards, and over the radio with the greatest of success. This radical step in Massachusetts, taken in the citadel of conservative and traditional medicine, was approved by the Massachusetts Medical Society—the oldest in the country. I can understand that it was not an easy decision for the medical profession to make, but now that we know that advertising of voluntary prepaid medical plans has been successful wherever it has been tried and that, therefore, it is in the interest of the potential members of the plans and of the communities at large, I hope that it will be adopted by voluntary plans throughout the country."

Mr. Larsen stressed the "impact of the ten million men who have been and who are being demobilized from our armed forces and of the thousands of doctors who have been practicing group medicine in the Army and Navy and the Air Forces" upon our society. They, he said, will have a dominant voice in the development of policies of the Nation in the next decade. They have been recipients of the finest medical care and hospitalization the country could provide. They, especially those in the lower income positions, "will have little patience with a system which does not favorably compare with what they experienced in our armed forces. We must make that available to them."

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Outlook for the General Practitioner

Too much emphasis is being placed on specialism, with the result that the prestige of the general practitioner is being lowered. At least that is the opinion of Drs. S. A. and S. B. Thompson expressed in an article appearing in the June 8 number of the *Journal of the American Medical Association.*

Writing on the subject, "The Status of the General Practitioner, Present and Future," Drs. Thompson say: "Our purpose . . . is to point out a trend toward the concept that only specialists are qualified to treat patients, to question the validity of this concept and to present a plan to halt or reverse this trend. It is not our purpose to question the importance of highly trained specialists in the treatment of patients: simply to question the necessity of their treating all patients."

How do they hope to halt this trend? Here are their proposals:

> "1. Recognition of the general practitioner by regimented medicine [this includes the medical service of the military services, the Veterans Administration, medical teaching centers, certain industrial medical plans and other similar systems] through:
>
> A. Staff appointments for general practitioners in teaching centers; B. general practice services in teaching, military and Veterans Administration hospitals; C. perpetuation of the Veterans Administration's system

for care of the veteran in his local community with general practitioners participating.

"2. Elimination of causes for criticism of the general practitioner through:

A. Standardization and improvement of training of general practitioners; B. limitation of the work of the general practitioner to that for which he is adequately trained.

"3. Organization of general practitioners to implement these proposals.

" 'There are in the United States today some 160,000 practicing physicians, of whom only slightly more than 20,000 are certified by the various specialty boards as qualified in their chosen fields.' [This makes] a ratio of one specialist to eight general practitioners. . . ."

In support of these proposals, Drs. Thompson point to the economic waste involved in specialty care for routine conditions; increased life expectancy in the past fifty years from 33 to 60 years (90 per cent of the medical care during this period was rendered by general practitioners); reduction of maternal and infant mortality; and the elimination of infectious diseases.

Smaller communities in which there are few specialists have fared better from the standpoint of health than the large urban centers where specialists predominate. Even granting that social conditions in these communities are more conducive to health than are those of the city slums, the authors ask, "Can the businesslike chief resident, or even the suave professor, hope to compete with the well known and beloved family physician in persuading a family to modernize its toilets, cover its garbage can or inoculate its children?"

Drs. Thompson do not overlook the familiar argument that the family physician knows his patients intimately and this knowledge is superior to the best history that can be taken by the specialist. "Many fruitless diagnostic procedures could be avoided and money, suffering and time saved if patients consulted the general practitioner and the appropriate specialist recommended by him."

Examples offered to illustrate the present trend are the efforts to perpetuate the Emergency Maternal and Infant Care program for all families. A committee from the Advisory Board to the Children's Bureau recommended that only certified specialists be allowed to participate in this program. The Advisory Board did not accept the committee's report, but according to the authors, it shows the trend in thinking. In medical teaching centers, where students, interns, and residents are trained and where low income groups receive their medical care, the trend is also apparent. Likewise, in private practice, the emphasis is on specialization.

The remedies suggested by the Drs. Thompson appear to your Observer as being sound and worthy of serious consideration by medical organizations throughout the country.

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Health Survey in the Headlines

Newspapers have taken to the report on the Health and Hospital Survey sponsored by the Washington Metropolitan Health Council "like a duck to water." No survey within your Observer's memory has held the front pages of the newspapers for so long a time as this one. This was largely due to the content of the report, but that is not the whole story. As a matter of fact its "hitting the front page" day after day was accidental. Because of mechanical and other difficulties, the whole report could not be released at once and it was necessary to make it public by sections. As a result, the vigorous and penetrating findings and recommendations of the surveyors became in newspaper parlance "spot" news.

One feature of this publicity is to be regretted. The impression was somehow given that the recommendations of the surveyors were those of the Council, which, of course, is not true. It is no one's fault, least of all the Council's, whose officers endeavored to clarify the situation.

Dr. Herbert P. Ramsey, Chairman of the Council, stated at the public meeting when highlights of the survey were presented that the views of the Council might not coincide with those of the surveyors. He said, too, that hearings would be held by the Council's Survey Committee and later by subcommittees at which time an opportunity would be given all interested groups to present their views, following which the Council would act upon the report.

As previously stated, the surveyors "laid it on" with good effect, especially in their hospital investigation. As is well known, the physical plants of Washington hospitals, except for Doctors Hospital, which ranks with the best in the country, have been a disgrace.

The Health Security Administration came in for severe criticism, more so than many who are familiar with the operation of this agency believed justified. However, the Administration is capable of defending itself. It will also have the support of its sponsoring organizations, among them the Medical Society.

At the Annual Business Meeting of the Society in May, the following resolution was presented and adopted:

> "RESOLVED, That the Executive Board be and is hereby requested (1) to submit to the Society as soon as practicable, and not later than June 30, 1946, an objective analysis of the report made public by the Metropolitan Health and Hospital Survey April 30, 1946, on hospitals and medical services in the District of Columbia; (2) to submit with that analysis detailed recommendations for such action by the Society as the Executive Board deems proper; and (3) to send a copy of its analysis and recommendations to every member of the Society not less than ten days before the meeting of the Society at which they are to be submitted."

Before these lines appear, a report will undoubtedly have been made to the Society as instructed in this resolution. Whatever one's views of the findings may be, there is no denying that a thorough job was done by the investigators. If their study will stimulate the people of this community to realize their obligations and responsibilities with respect to health facilities and make officials in responsible positions in the health field more sensitive to their obligations, it will have more than fulfilled its purpose. Of course there must be action, and prompt action on some of the recommendations.

Mention should be made of the fact that it was largely due to Dr. Ramsey's able leadership that this project was carried to completion. The Society may well be proud of his outstanding and unselfish service to the community.

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In the Same Channel

Few writers have anything original to contribute. Most of what they write is a rehash of what has been said many times before. Your Observer most certainly does not lay claim to originality. Often what he thinks is a good idea and perhaps a new one, he learns is very, very old.

In looking over the current medical journals the other day, he came across an editorial, "Motorcade," in the May 30 issue of the *New England Journal of Medicine.* The following paragraph attracted his attention for reasons that will become obvious.

> "It cannot be doubted that many of our citizens, commonly respected and accepted as decent members of society, legally married and the parents of small children, still have two sides to their characters—the Dr. Jekyll side, using their reputations as a sort of guarantee of irreproachable conduct, and the Mr. Hyde side, the latter manifesting itself when they are behind the wheels of moving automobiles. There is a hypnosis to swift vehicular travel that affects us all somewhat as it did the reptilian hero of 'The Wind in the Willows.' It sets us on edge; it removes our sense of propriety and puts us in open conflict with all our fellows, even if it does not turn us into the scoundrels that the law, afoot or awheel, seems to consider all human beings awheel to be. All scoundrels, it is true, may at times drive motor cars; it does not follow that all drivers of motor vehicles are to be considered scoundrels until proved otherwise."

There was, of course, much more to this editorial and this paragraph was not necessarily the most important. But it did stir memories. Your Observer recalled an editorial he had written many years ago. Upon investigation he discovered that it had appeared in the September

1930 number of the *Milwaukee Medical Times* and was entitled "The Modern Dr. Jekyll and Mr. Hyde." A portion of this editorial reads:

> ". . .Certainly Dr. Jekyll and Mr. Hyde have their prototype today in the modern motorist. Away from his automobile the average motorist is the gentlest and most mannerly of men, but once his hands are on the wheel what a transformation! No longer is he patient with the other fellow and no longer does he observe good manners. The smallest incident provokes his wrath. An innocent pedestrian who retards his speed will be roundly cursed. Speed is essential. Tearing down the street with his hands tightly gripped on the wheel, a tense expression on his face, he blows his horn loudly for all to clear the way. Without the slightest excuse he will crowd in where there is no room—anything to get out in front. If he cannot get by on one side or another he will snarl at the supposed offender. His impatience with the slow driver is shown by the 'dirty look' as he passes. At a stop-and-go sign he will crowd forward by degrees until he is nearly in the middle of the street before the green light indicates 'go.' That pedestrians might want to cross bothers him not at all. If the eyes of the law are not on him he is not averse to scampering across—lights or no lights. As often as not 'arterial stop' signs might as well have the 'stop' left off. His main purpose is to make time."

There is not much purpose in comparing these items except to show that our minds run pretty much in the same channels. Undoubtedly others have used the same illustration to prove a point. In other words, originality is a mighty scarce commodity. What makes it seem so in written material is usually a distinctive style or manner of presentation.

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Hold On to the Good

In our country, a middle-of-the-road course usually prevails despite bitter attacks from the right and left. This is particularly true in politics, for which, in these times, we Americans can be grateful.

A month or two ago your Observer appeared on a broadcast in which the merits and demerits of compulsory health insurance were discussed. His opponent held his temper while the broadcast was in progress but afterward indulged in an outburst against physicians and present-day methods of practice. Somewhat irked, your Observer came back with the statement that the opinions of leftist crusaders were usually discounted by the public. His opponent retorted scornfully that he would do everything possible to bring about a complete overhauling of medical practice. It might be well to explain that this man is not a physician and is widely known for his advocacy of a government-controlled system of medicine which would completely eliminate private practice.

Now, medicine is not endangered too much by extremists. They are and probably always will be in the minority in this country. But there is danger in these times when doctors are under great pressure that they lose their perspective. Dr. Cleveland Thompson, President of the Medical Association of Georgia, was thinking along these lines when he addressed his Association last May.

> "The physician of today," Dr. Thompson said, "is confronted with a volume of practice unthought of a few years ago. Not only is the population per physician greater, but money is more plentiful and the public is better educated in preventative medicine. The cancer educational program and similar programs send thousands of patients to doctors' offices who had never thought of getting a physical examination. This burden of work makes it very hard to give the best we have to every patient we see, yet the instant we cut short an examination, through weariness or other reasons, we are courting tragedy. It is moreover difficult for the tired and overstrained doctor to be as cordial and painstaking as the public expects, and as he wants to be. He has to find the emotional complications and mental anguish that may be at the root of the patient's physical complaints. He has to know and correlate the many things affecting his patient that are not found in the clinical laboratory nor by the X-ray. He not only has to supply acceptable service to people normally, but he has to deal with little people when they are big, as well as with big people when they are little. These are the things that make such a tremendous demand on his time, his body, and his mind.
>
> "But in this new day our profession is more than ever dependent upon the traditions and the ethics of the past. Although 'change is the law of life,' we know that 'If the

new has no root in the old, it withers. If the old grows no new leaves it dies.' "

However, Dr. Thompson is not one of those who believes the status quo must be maintained at any cost. On the contrary, he says physicians must reorient their thinking.

> "The average doctor is so consumed with the work of his profession that he does not read all of the scientific material that comes to him, much less that relating to the problems of medical economics and the threat to him and to his people of the socialization of medicine. But the change in the situation which we face today has come about so rapidly and so decidedly that we must revise our habits of thinking and planning. The proposals in Britain's Health Act are a distinct shock to us, that her hospitals and medical men be taken over by the government. Britain's men of science have fought long years against these socialistic threats. It is incongruous indeed that a nation bled white by its battle for democracy should stand waiting to make pawns of the members of her most distinguished profession—men who have maintained a dignity and scientific progress revered by the enlightened world.
>
> "I believe that the most urgent responsibility and duty of the Medical Association of Georgia today is the development of an acceptable comprehensive voluntary insurance plan in accord with the principles laid down by the American Medical Association in its National Health Program—a program planned to protect every citizen of the state and of our country against the high cost of sickness, and of hospitalization. Twenty states have already set up this program, and recently our sister states South Carolina and Florida have completed theirs. We cannot disregard the growing interest of the public in a prepayment program. They want scientific medical care, but they also want some provision made by which they can pay for it. Organized medicine has gained enough experience for us to offer now something constructive, and something which should be beneficial. The problem is difficult, but the need is immediate, and the stakes are too high for all concerned to permit of longer delay. Let not those who follow us say that we did 'too little too late.' "

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Brotherly Love Those of us who read medical journals regularly usually find little in them that is exciting. In fact, they usually provide us with quiet, and too often dull, reading. So your Observer was not prepared for the jolt he received when he picked up the *Weekly Bulletin of the St. Louis Medical Society* for May 24. In looking over the editorial, "Ask the Man Who Has Been There," he found the usual arguments against the Wagner-Murray-Dingell bill and this startling statement, "Why wouldn't it be better, therefore, to set up an experimental system for the administration of medical care to test the efficiency and applicability of the principles promulgated in this piece of pending legislation, before advocating its adoption for the country as a whole? Why wouldn't the District of Columbia be ideal to use as a guinea pig for the conduct of this experiment? Then perhaps it would be possible to kill two or more birds with the same stone."

That is certainly considerate of the editor, but your Observer believes that the 1,400 practicing physicians in Washington would not want to deprive St. Louis of the privilege of being the "guinea pig." It would be peculiarly fitting for St. Louis to be so honored. After all a Missourian, now residing in the White House, would undoubtedly be gratified by such a demonstration of liberalism. So would other Missourians in the Nation's Capital, for there are lots of them here.

Citizens of Washington are used to having things "tried out on the dog" in their fair city. But voteless doctors in the District are willing to pass up this opportunity in token of affection for their Missouri colleagues.

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Footnotes Thomas A. Hendricks, long the Executive Secretary of the Indiana State Medical Association, has become full-time Secretary of the AMA's Council on Medical Service and Public Relations. For several months he served on a part-time basis. Now "Tommy" is a full-fledged member of the official family at Chicago. His promotion is one more proof that lay executives in medicine have

(*Continued on page 359*)

WHY WE OPPOSE COMPULSORY HEALTH INSURANCE*

GEORGE BAEHR, M.D., F.A.C.P.

President, The New York Academy of Medicine

I appear before you not only as the representative of the Academy but also of its special Committee on Medicine and the Changing Order. This Committee was established by the Academy three and one-half years ago to make an intensive study of the many problems of medical care which have been and still are being created by the rapid progress of medical science and the changing world in which we live. It includes in its membership a large percentage of nonmedical persons representing various elements of the population. The Committee has spent hundreds of hours in deliberation, collectively and in subcommittee meetings, at which groups of experts have studied and dealt with specific phases of problems confronting present-day medicine.

It has been our desire, like yours, to find the best means of bringing the modern benefits of preventive and curative medicine to all the people of our country, rural and urban. We are not interested in preserving the "status quo" of medical practice. We are quite prepared to consider any changes in the methods of rendering medical services and in the methods of payment for medical care which may be better for the people.

The work of more than three years of the Academy's Committee on Medicine and the Changing Order has been completed and its report, which is now in preparation, will be published in the fall. You will, I feel certain, find it unbiased and constructive.

The Academy is fully cognizant of the many lacks in medical care which now exist in the United States and which most certainly are in need of urgent remedy. We are in complete agreement on the principle that the health of the people is a matter of national concern and that every effort should be made to provide all our people with adequate medical care. However, we are mindful of the great achievements of modern medicine, which have been effected, particularly during the last 40 years, under the prevailing system of medical practice. By the side of the many admitted inequities in the distribution of medical care stands the attested fact that no nation of comparable size and complexity, with as many varieties of circumstances under which its people live and work, has attained as much in fostering the health of its citizens. From our experience and our study of the problem, we feel certain that Title II of S.1606, which deals with National Compulsory Medical Insurance, will result in abrupt, nation-wide changes in medical practice which will destroy much of that high standard of medical care to which we have become accustomed in this country during the last 40 years, and which we take for granted. We are convinced that the objectives which the proponents of this bill have in mind, and which we share, can be achieved more quickly and more effectively by procedures that are far less hazardous. I shall present our recommendations after a brief consideration of the other sections of this bill.

We are substantially in accord with the provisions of the Hill-Burton bill, S.191, which deals with the construction of hospitals and health centers through Federal grants-in-aid to the states. The proposal for a careful preliminary determination of the needs of the various states and of their medically underprivileged areas is to be commended. To function effectively, such newly constructed rural and other hospitals and health centers must be adequately staffed with competent personnel. But we wish to point out that at this time there is not available, and the immediate future does not promise to provide, a large enough number of trained and experienced personnel to warrant a rapid expansion of hospital facilities.

In Title I of S.1606 we endorse in principle the proposed expansion in public health, maternal and child health services, and medical care for needy persons through grants-in-aid to the states. Whatever expansions are undertaken in these fields should be developed in relation to existing facilities now operated by state and local agencies, official and voluntary, many of which are excellent. More effective progress can be made in the field of maternal and child health by determining the areas of greatest need and concentrating the corrective measures where they are most needed than by dissipating limited assistance over that large part of our population which is well served by its own local facilities.

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* Presented at hearings on the Wagner-Murray-Dingell bill (S.1606) before the Senate Committee on Education and Labor, May 24, 1946.

We also endorse in principle the proposal to advance and support medical education and medical research. Here, too, governmental aid to medical education and research should be of such a character that it fosters and supports, but does not direct or dominate. For this reason, the Academy approves the Magnuson-Kilgore Bill now before the Congress, which has the support of practically all men of science.

Returning now to Title II of the bill (S.1606) which is entitled "Prepayed Personal Health Service Benefits," I must inform you that, in the public interest, the Academy is definitely opposed to its enactment on the grounds that national compulsory medical insurance at this time would lead to unfortunate results affecting the health of the public, and the science as well as the practice of medicine. The proposed scheme of prepayment of medical costs based upon the enactment of compelling legislation through the collection of a tax on payrolls is deceptive in its simplicity. Unfortunately, payment for medical care through insurance represents only a fragment of the problem. It is far easier to collect the insurance premiums than to deliver the services. An adequate number of competent physicians is not available to provide the medical services promised to the people of this country in return for their substantial contributions under this bill. It would take many years to develop the necessary educational facilities, to train the required number of physicians, and to endow them with an adequate measure of professional competence in their various special fields.

National compulsory medical insurance cannot create the services essential for improving and extending medical care and it is most certainly incompetent to raise the quality of medical practice. On the contrary, there is a wealth of experience which shows that under compulsory medical insurance on a nationwide scale, though a larger number of people receive medical care, the quality of medical services rendered by the individual physicians tends to decline. This deterioration in medical services results from the fact that the direct payment for medical services by a third party, the insurance fund, introduces a fundamental disturbance in the attitude of both the subscribers and the doctors. The patient is tempted to demand more attention than he requires. Still more serious is the temptation presented by the scheme to the practitioner to add to his income by rendering unnecessary services. Under present methods of payment, the financial rewards for volume of service and the pressure of patients constitute a combination of influences which is difficult to resist. The inevitable result is superficial performance. This has been the recent experience in New Zealand and it has been our own experience in the operation of Workmen's Compensation Insurance in New York State.

This observation is especially true when physicians are paid an individual fee for each service, one of the methods of remuneration authorized under S.1606. The alternative method of payment, namely, capitation, whereby an annual stipend is paid to the physician for each insured patient on his list, likewise produces objectionable results. When the financial reward is fixed, some physicians are tempted to render as little service as possible.

Immediate application of compulsory coverage of the entire low-income population would also have serious implications upon medical education, upon which the future standards of medical services for our people so largely depend. Sudden nationwide coverage would also disrupt the graduate training of hospital internes and residents upon whom we must depend to meet our ever growing need for internists, surgeons and qualified specialists under any expanded system of medical care. These are not matters to be taken lightly if our people are to be well served medically.

However, we feel sure that medical services under a prepayment system can be worked out under carefully planned local and state controls. At the present time, we in the United States do not know how best to develop comprehensive medical insurance which will meet the needs of our people, nor what adjustments must be made to protect medical education and medical standards. We lack experience not only from the actuarial angle but, what we at the Academy consider still more important, from the service aspect. As a result of our studies, we are convinced that the problems involved in the improvement and extension of medical service to the people of the United States are numerous and diverse; and that the ways to their possible solution are, and must be, of many kinds. The states differ widely in the nature and degree of their deficiencies in medical care; there are extreme differences between various parts of each state and certainly between rural and urban areas which call for different methods of treatment.

We, therefore, recommend that you abandon this plan for immediate nationwide compulsory medical insurance and frame an entirely new bill that will provide a reasonable program of Federal grants-in-aid to the states for the study and development of state and local programs of medical care, which are designed to meet local needs and which conform to acceptable standards of medical service. In this country, the provision of general medical care has always been a local responsibility except for such conditions as mental disorders and tuberculosis, which require prolonged hospitalization. The major existing deficiencies in local medical facilities and services can best be corrected by providing sufficient state and Federal assistance to raise local medical resources to a desirable level. Entirely different procedures will be required in some rural areas than in urban centers and not all urban communities need identical treatment.

The principle involved in our proposal is identical with that employed in the Hill-Burton bill (S.191) for aid to the states in the construction of needed hospitals and health centers. The proponents of the Wagner-Murray-Dingell bill have accepted this principle in Title I of S.1606. In S.191 provision is made for the preparation of statewide hospital surveys under competent auspices and for the subsequent development of hospital facilities needed by local areas. We propose that a parallel program of Federal and state assistance be followed in regard to medical care.

As a major feature in the proposed medical care program, the Academy recommends, among other things, that voluntary, nonprofit insurance be given a thorough trial as a means of providing medical services to low-income families. At the same time it recognizes that plans of this nature cannot be expected to solve the entire problem and that when private resources are inadequate, government support, preferably in the form of Federal or state grants-in-aid, will be required. Governmental assistance will also be required for the payment of insurance premiums or other subsidies for the indigent and the unemployed. Such assistance would assure a reasonable measure of financial stability to local or statewide voluntary nonprofit plans and would provide an opportunity to require high standards of medical service.

The Academy holds, further, that it may be desirable to conduct an experiment in at least one of the states with compulsory government insurance, so that we may have in the near future comparable experience with the relative values of voluntary and compulsory procedure.

In order to improve the quality and the scope of medical care under any system of payment, the Academy favors not only a revision in medical education, but the gradual extension of group medical practice. Under this form of practice, doctors conduct a joint enterprise in medical care in close coöperation with high grade hospitals or health centers which are affiliated with a nearby hospital, and they share a common plan of remuneration and responsibility for the services which they render. Even those physicians who settle in rural communities should eventually be able, under a well planned system of medical care, to retain or establish such a relationship to a medical center.

Group medical practice, of which there are already many examples in the United States, promises far-reaching improvements in the organization of practitioners and specialists under more modern conditions of practice. Under this system, the central facilities and the combined training and experience of the entire medical group are at the disposal of the general practitioners associated with the unit. Under a prepayment system independently practicing physicians will, in this country, almost universally prefer the fee-for-service method of remuneration, whereas medical group practice units will accept or even prefer the capitation method of payment. The group is able to use its annual prepaid income for subscribers more economically and efficiently than an equal number of independent physicians. Group practice can provide complete modern service for preventive and curative medicine which people of low and even medium income cannot afford under our present system of "solo" medical practice. It is to the distinct advantage of medical practice groups remunerated by annual per capita payments to apply all modern measures for the prevention of disease so as to reduce their operating costs. Group medical practice offers new opportunities for the advancement of preventive medicine and the earlier recognition and cure of disease.

Unfortunately, there are too few medical practice groups in operation at present to influence the general quality of medical care, and we feel sure that the organization of any large part of the medical profession into groups will not be materially enhanced by Title II of S.1606. Group medical practice can be developed widely only through local medical initiative and local public encouragement based upon plans for medical care which are designed to meet local needs.

It is essential, moreover, that medical group practice be organized also in relation to teaching hospitals so that medical school and teaching hospitals may train doctors not only in the science of medicine but in this more modern and better form of medical practice. For these and other reasons, it would be eminently desirable that local and state plans provide a special measure of incentive for the wider development of group medical practice related to qualified hospitals and their affiliated health centers.

It is impossible to go into more detail at this time, but enough has been said to indicate the nature of the intricate problems of medical care and medical education into which any widespread system of prepayment will plunge us. What this country needs at this time is not an over-all national compulsory scheme applied as a panacea to all or to most of the people without regard for its implications upon the delivery of medical services and the protection of existing standards. As a result of our studies and experience, we are convinced that an evolutionary transformation of medical practice is necessary if the full benefits of modern medicine, and especially of preventive medicine, are to be made more freely available to the people. Our proposals are designed to accomplish this objective in an orderly manner throughout the country through a variety of projects by smaller units at state and local levels.

IMPORTANT NOTICE TO PHYSICIANS

Dr. Edgar P. Copeland, State Chairman of the Academy of Pediatrics for the District of Columbia, urgently requests that those who have not returned the forms sent them in connection with the local Study of Child Health Services do so at once. The coöperation of each individual physician is important.

MEMBERSHIP

The following applicants for membership were duly elected to membership at the meeting of the Executive Board, June 24, 1946, in accord with Amendment XI, Section 2, of the Constitution and By-laws of the Society:

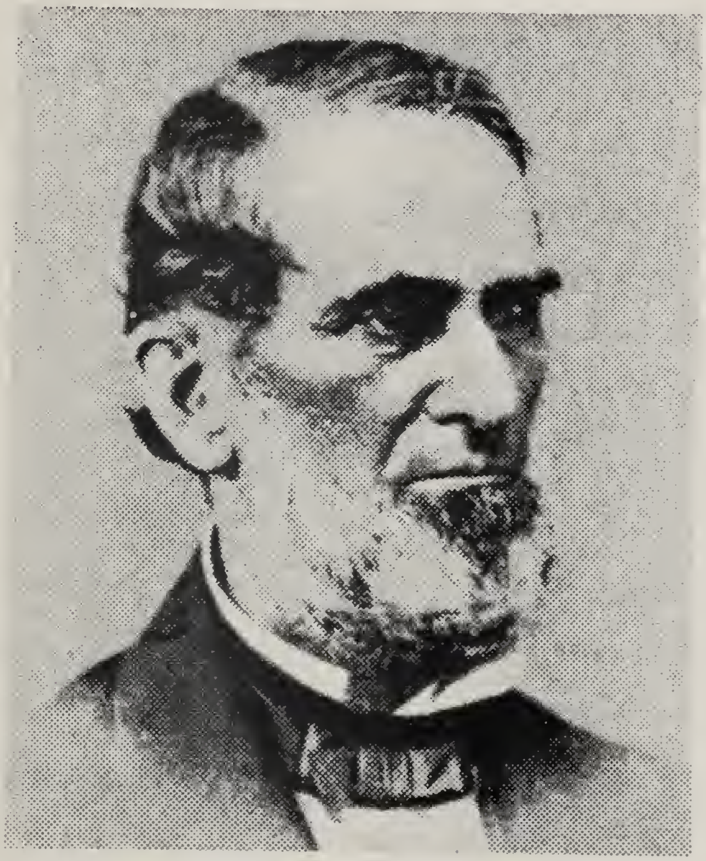
Active Members

Norman Q. Brill, 1712 Rhode Island Avenue, N.W.
John Richard Cain, 1438 Columbia Road, N.W.
Paul Chodoff, 2014 R Street, N.W.
Stewart Clapp, 3921 Ingomar Street, N.W.
Philip A. Cox, Captain, M.C., Army of the United States
Jacob M. Danish, Gallinger Municipal Hospital
Paul Elsberg, Hunting Terrace Apartments, Alexandria, Va.
Edward E. Ferguson, 1801 Eye Street, N.W.
Andrew E. Fischer, 1252 Sixth Street, S.W.
Samuel Fishman, 1414 Underwood Street, N.W.
William T. Gibb, Jr., 2002 R Street, N.W.
Thomas J. Kelly, 4001 South Dakota Avenue, N.E.
Samuel D. Loube, 2827 N. E. 14th Avenue, Portland, Ore.
William S. McCune, 2025 Eye Street, N.W.
G. Foard McGinnes, National Headquarters, American Red Cross
George I. Mishtowt, Gallinger Municipal Hospital
William R. W. Moses, Gallinger Municipal Hospital
Thomas W. Murphy, 4704 Reservoir Road, N.W.
Dee Rich Parkinson, 2000 F Street, N.W.
Carl John Potthoff, 930 H Street, N.W.
Robert Stolar, 1726 Eye Street, N.W.
John W. Walsh, 2023 R Street, N.W.
Allen Widome, 5109 2nd Street, N.W.
Vincent T. Young, 1801 K Street, N.W.
Anthony Zappala, 203 E. Franklin Avenue, Silver Spring, Md.

Associate Members

Alvin B. C. Knudson, 4104 S. 36th Street, Arlington, Va.
Jasper W. McFarland, 6856 Eastern Avenue, N.W.
Richard B. Phillips, 8248 Georgia Avenue, Silver Spring, Md.
Alfred H. Richwine, 5522 Western Avenue, Chevy Chase, Md.

Washington Physicians of Yesterday



JAMES CROWDHILL HALL, M.D.

Certainly Dr. James Crowdhill Hall was one of the outstanding Washington physicians of his time. He was the family physician of every President of the United States from Jackson to Lincoln. He also attended the families of Justices of the United States Supreme Court, cabinet officers, prominent members of the House and Senate, and the heads of many Government departments. His services were much in demand at the foreign legations. So there can be no question about Dr. Hall's high professional standing in Washington in the middle 1800's.

His biographer relates that while some people thought he was testy, he was generally liked because of his generous and unselfish nature. He contributed more money to charitable purposes, according to Dr. Samuel C. Busey, "than the entire medical profession combined."

Born in Alexandria, D. C., January 10, 1805, Dr. Hall attended Jefferson College, from which he graduated in 1823 with a B.A. degree. He received his degree of Doctor of Medicine from the University of Pennsylvania in 1827.

Dr. Hall was an incorporator of the Medical Society under its second charter and studied medicine under Dr. Thomas Henderson, one of the incorporators of the Society under its original charter.

After graduation he was resident physician for one year at Blockley Hospital, Philadelphia. From 1830–1839 he was Professor of Surgery at Columbian College, Washington.

Dr. Hall died suddenly on June 7, 1880.

Veterans' Affairs

A MESSAGE TO OUR VETERANS

William Earl Clark, M.D., F.A.C.P.

President, The Medical Society of the District of Columbia, 1945–46

The Medical Society planned to have a Veterans Night during the month of May. Dr. Hunter, Chairman of the Program Committee, was very enthusiastic about this night of welcome and gave a luncheon to a group of us, and after the luncheon we worked out a most attractive program. We had hoped to have the Secretary of War and the Secretary of the Navy as speakers, and the Marine Band to add to the occasion. We hoped to have you veterans and your wives, and as many of the members of the Society as could come. I had hoped to make a short speech of welcome on that occasion.

But our plans for this gala occasion did not work out. We were unable to secure the speakers for May, and as hot weather was approaching, and about one fourth of the men were still in the Service, we decided to postpone Veterans Night until the early fall when everyone could be present.

As retiring President of the Medical Society I do want to express my welcome to the veteran physicians who were separated from the Service and are now going through the stage of getting back into civilian practice. I have had the pleasure of greeting many of you personally, but there are many that I have not seen and I do want at this time to say how glad we are to have you back.

Many of us were with the armed forces during World War I and know rather well the problems that face the returning veteran physicians. World War I did not last nearly as long as this last war, and we were not separated from our practices more than eighteen or twenty months. Many of us were able to keep our offices and our cars, so that they were available when we returned. In general I think most of our patients returned to us within a few months after we reopened our offices. At least in a relatively short time we had sufficient practice to enable us to carry on. Hospital privileges were not in vogue at that time, if my memory serves me right. Anyone who had reasonable credentials could send cases into most of our city hospitals. I do not remember much difficulty about staff appointments or teaching positions.

This time I understand there has been some difficulty here and there, not so much with courtesy privileges as with staff and teaching positions. Some hospitals seemed inclined to give the men who had stayed at home and served the hospital during the war years priority over those who had been with the armed forces. That is, when it came to advancement or appointment on the teaching staff the veteran physician on some occasions lost out. It seems to me that any man who has been on the staff of a hospital, or who has been teaching at one of our medical schools, was just as truly serving that institution when he was with the armed forces as when he was working here at home.

Probably most of us who stayed at home this time worked as hard or harder than we ever worked in our lives before, but we were in our own homes, we drove our own cars, and we had a good financial return for our work. In general we were living under more comfortable circumstances than you men in the Service. Therefore, as I see it, you have the right to not only expect to have your courtesy privileges granted promptly, but I hope too that the hospitals and the medical schools will let you retain your seniority rights and that you will have a fair chance of advancement.

Again I want to say how very much this housing shortage and lack of office space have caused us concern. I am under the impression that most of the men now have offices where they can carry on, even if they are not wholly adequate or satisfactory. I feel sure as the months pass that better homes and better offices will be available, and I sincerely hope that the years in the Service have not worked too much of a hardship on you, and that your practices are increasing in a satisfactory manner.

In general I think men who have served as physicians with the armed forces during wartime get a great deal of personal satisfaction from having done so. I know I felt thrilled to be a part of the biggest thing that was going on in the world at the time I was in the last war. I feel sure you will have an increasing sense of satisfaction as the years pass when you look back on your war service.

In regard to settling back into life at home, there seems to be more chance for younger men today than ever before. There never were so many relatively young men holding high office as there are today. I struck some lines in a book I am reading at present that I liked a lot, and they seem very true. "These young people are franker, wiser, more sophisticated than we were; more eager and courageous about life. . . . Youth always has had too much to live for anyhow to be anything but fundamentally decent." In spite of the social trends in medicine I feel you younger men who served as medical officers will adjust yourselves to these changing conditions and carry the ideals of medicine to an even higher level.

May I wish you all good luck and success in the years to come.

NEW PROMOTIONS IN RANK

Reports on promotions in rank are still being received at the Society's office. Many of them have been long delayed. As they have not previously appeared in the MEDICAL ANNALS they are included with a list of recent promotions. Most of the members listed below have returned to civilian practice.

Victor R. Alfaro, from Major to Lieutenant Colonel
Walter Atkinson, from Lieutenant Colonel to Colonel
Robert M. Bolton, from Commander to Captain
Ralph M. Caulk, from Lieutenant to Lieutenant Commander
Austin B. Chinn, from Major to Lieutenant Colonel
Milton C. Cobey, from Major to Lieutenant Colonel
Robert J. Coffey, from Lieutenant to Lieutenant Commander
John L. Conley, from Lieutenant to Lieutenant Commander
Linn F. Cooper, from Lieutenant Colonel to Colonel
J. Keith Cromer, from Lieutenant Commander to Commander
Jack L. Derzavis, from Lieutenant to Lieutenant Commander
Mazarin C. Dollman, from Lieutenant Colonel to Colonel
John F. Donohue, from First Lieutenant to Captain
Charles E. Fierst, from Major to Lieutenant Colonel
Stuart O. Foster, from Lieutenant Colonel to Colonel
Oscar H. Fulcher, from Commander to Captain
Frank B. Geibel, from Commander to Captain
Edward J. Grass, from Lieutenant Colonel to Colonel
Henry A. Hornthal, from Lieutenant Commander to Commander
William A. Howard, from Major to Lieutenant Colonel
Charles R. Hughes, from First Lieutenant to Captain
Oscar B. Hunter, Jr., from Captain to Major
Camp S. Huntington, from Captain to Major
Howard Katzman, from Major to Lieutenant Colonel
Edward A. Kelly, from Major to Lieutenant Colonel
Ben Klotz, from Lieutenant Commander to Commander
Daniel F. Lynch, from Lieutenant Commander to Commander
Raymond Maret, from Major to Lieutenant Colonel
Gerald H. McAteer, from Lieutenant Commander to Commander
Marvin M. McLean, from Lieutenant Commander to Commander
Clarence L. Miller, from Captain to Major
William S. Miller, from Major to Lieutenant Colonel
Reginald H. Mitchell, from Lieutenant Commander to Commander

Clyde P. Reeves, from Captain to Major
Marshall deG. Ruffin, from Major to Lieutenant Colonel
Samuel Shwartz, from First Lieutenant to Captain
Luther H. Snyder, from Lieutenant Colonel to Colonel
Charles W. Thompson, from Lieutenant to Lieutenant Commander
Alfred Wilson, from Major to Lieutenant Colonel

MORE WASHINGTON PHYSICIANS RETURN TO PRACTICE

Most of the Society's members who served in the armed forces have now returned to their practices in the District of Columbia. A few are establishing themselves in cities far removed from Washington. With the latter go the good wishes of the Editorial Board together with the hope that they will visit Washington from time to time to renew old friendships. The Board welcomes the physicians listed below who have returned to civilian practice within the past few months but whose names have not previously appeared in the ANNALS. As the remaining members in service return to Washington their names and addresses will be published.

Victor R. Alfaro, 8007 Massachusetts Avenue, N.W.
Walter Atkinson, 1835 Eye Street, N. W.
Joseph F. Belair, Providence Hospital
Crenshaw D. Briggs, 1835 Eye Street, N.W.
William K. Billingsley, Jr., 1746 K Street, N.W.
John L. Cardwell, 1371 Kalmia Road, N.W.
Frank T. Cawley, Memorial Hospital, Cumberland, Md.
Ervin N. Chapman, 1901 Wyoming Avenue, N.W.
Andrew N. Conte, 886 South Broad Street, Trenton, N. J.
Linn F. Cooper, 2222 Que Street, N.W.
J. Keith Cromer, 1901 Wyoming Avenue, N.W. (temporary)
Alva D. Daughton, 1725 N Street, N.W.
Stuart O. Foster, 2025 Eye Street, N.W.
Oscar H. Fulcher, 5081 Lowell Street, N.W.
Edward T. Gary, 4510—46th Street, N.W.
Ralph J. Haws, R.D.1, West Leesport, Pa.
Henry A. Hornthal, 2100 Massachusetts Ave., N.W.
O. B. Hunter, Jr., 1835 Eye Street, N.W.
Camp S. Huntington, 3231 Gunston Road, Alexandria, Va.
Richard L. Jackson, 1344—19th Street, N.W.
Howard F. Kane, Machias, Maine
Stephen E. Kramer, 1147 Longwood Avenue, Pueblo, Colo.
John Louzan, 105 North Alfred Street, Alexandria, Va.
E. Stuart Lyddane, 3066 Que Street, N.W.
Wilkins R. Manning, P.O. Box 2448, Tucson, Arizona
Raymond Maret, 1291 Brentwood Road, N.E.
Clarence L. Miller, 1465 Rhode Island Avenue, N.W.
Ferdinand H. Mistretta, 3 Wetherill Road, Westmoreland Hills, Md.
Benjamin J. Mundell, 1616 Rhode Island Ave., N.W.
Jed W. Pearson, Jr., 1834 K Street, N.W.
Marshall deG. Ruffin, 1835 Eye Street, N.W.
S. Hazen Shea, 1801 K Street, N.W.
Carl Silverman, 2420—16th Street, N.W.
John B. Smith, R.R. 1, Clayton, Ohio
Charles P. Waite, 4700 Connecticut Avenue, N. W.
Simon C. Weiner, 100 Longfellow Street, N. W.
Alfred Wilson, 1418 Good Hope Road, S.E.

ARMY AND NAVY ACT JOINTLY TO RELIEVE MEDICAL OFFICER SHORTAGE

The War and Navy Departments have announced joint action taken to relieve a very serious shortage of medical officers which now exists in the combined requirements of the Army, Navy and Veterans Administration.

Regardless of date of entry on active duty, only a two-year period of service will after July 1 be required of all Army Medical Corps officers, including graduates of the Army Specialized Training Program, except critically needed specialists. A two-year period of service will be required for all Navy graduates of the Navy Medical V-12 Training Program, who after March 1, 1946 were or will be ordered to active commissioned duty upon completion of internship. Navy doctors already separated will not be recalled. Under the Army's new two-year policy, it is estimated that approximately sixty days after July 1 will be required to complete the release of approximately 3,000 Army doctors affected by the change.

By the above action the requirements both of the Army and Navy can be met and in addition the Army can make available to the Veterans Administration approximately 1,000 badly needed medical officers and the Navy about 500.

It should be noted that extension of the period of service required for Navy doctors applies only to those whose education was subsidized by the Federal Government in the V-12 or the ASTP programs.

News and Personals

A. LOUISE ECKBURG

News Editor

The new **Hospital Council of the National Capital Area** completed its principal organization at a meeting of representatives from most of the 25 hospitals in the Metropolitan Area at Emergency Hospital, June 12, following an earlier meeting, May 27, also at Emergency Hospital, when bylaws were adopted tentatively. The new organization excludes representatives from the public and from agencies other than hospitals.

The following are officers of the new Council: President, William R. Castle, President of the Board of Directors of Garfield Hospital; Vice President, Robert G. Whitton, Administrator of Alexandria Hospital; Secretary, Sister Marie, President of the Board of Directors and Administrator of Providence Hospital; Treasurer, Mrs. Walter E. Perry, Vice President of Suburban Hospital. The officers are to serve for the ensuing year or "until their successors have been elected."

An Executive Committee of 12 were elected as follows, each one the superintendent or the administrative head of the hospital noted except as indicated:

For three years: J. G. Capossela, Emergency Hospital; Leo G. Schmelzer, George Washington University Hospital; Arthur G. Solon, Suburban Hospital; and Karl York, Arlington Hospital.

For two years: Charles Bradley, Trustee, Columbia Hospital; Dr. J. H. Hall, Freedmen's Hospital; Henry P. Blair, Vice President, Episcopal Hospital; Charles D. Drayton, President, Children's Hospital.

For one year: Dr. Alvin R. Sweeney, Gallinger Municipal Hospital; Dr. Edgar A. Bocock, Doctors Hospital; Dr. John M. Orem, Sibley Hospital; Dr. Francis J. Eiseman, Garfield Hospital.

Appointed to the Finance Committee were George A. Garrett, President, Emergency Hospital; Arthur G. Lambert, Trustee, Suburban Hospital; Colonel N. L. McDiarmid, Superintendent, Columbia Hospital.

CALENDAR OF MEETINGS

June 3	Program Committee, 17th Annual Scientific Assembly
June 5	Committee on Medical Care—hearings on prepayment plan
June 6	Grievance Committee Interprofessional Conference
June 7	Classification Committee
June 11	Board of Censors
June 14	Committee on Medical Care Subcommittee on Venereal Disease
June 18	Board of Censors
June 19	Special Business Meeting of Society
June 24	Executive Board

The Program Committee will consist of Mr. Schmelzer; Dr. Sweeney; Paul B. Cromelin, member of Board of Directors, Sibley Hospital; Dr. Henry L. Darner, Secretary, Board of Directors, Emergency Hospital; and Sister James Joseph, member of Executive Committee, Georgetown University Hospital.

Only hospitals are members of the Council; each hospital has three representatives on the Council, its administrative head and two others designated by its governing board. The member hospitals must be approved by the American College of Surgeons.

In order to expedite the **reviewing of new books** which arrive in the Society's office and at the same time to compensate in part for the services of the faithful reviewer, the Medical Society will henceforward donate the book received for review to the person who reviews it.

At the April meeting of the **Executive Board** approval was given to the following committee chairmen for the 17th ANNUAL SCIENTIFIC ASSEMBLY. The names were submitted to the Board by President William Earl Clark.

Program: Robert J. Coffey
Attendance: Luther H. Snyder
Finance: Harold M. Hobart
Scientific Exhibits: Emil J. C. Hildenbrand
Motion Pictures: A. Frank Kreglow
Public Meeting: Arnold McNitt
Social Affairs: Herbert P. Ramsey
Women Physicians: Helen G. Kain
War Souvenirs Exhibit: J. Lawn Thompson, Jr.

Dr. W. Ross Morris is General Chairman for the ASSEMBLY and Dr. Robert H. Groh, Vice Chairman.

At the **102nd Annual Meeting of the American Psychiatric Association** held in Chicago, May 27–30, Dr. Samuel W. Hamilton, mental hospital adviser to the U. S. Public Health Service, was elected President, and Dr. Winfred Overholser, Superintendent of St. Elizabeths Hospital, President-elect.

At the same meeting Dr. George D. Weickhardt was elected to membership, Dr. Frank S. Caprio to Associate membership, and Drs. J. L. Hoffman and Robert T. Morse to Fellowship in the Association.

Dr. Oswald Theodore Avery of New York City was awarded Georgetown University's annual **Kober Foundation Medal** in recognition of his investigations in connection with pneumonia, the University announced May 23. Selected as the Kober Medalist for 1946 by the Association of American Physicians, he was presented with the award on May 29 at the Association's meeting in Atlantic City, N. J.

A native of Halifax, Nova Scotia, Dr. Avery was graduated in medicine from Columbia University in 1900. His work with the Rockefeller Institute of Medical Research in New York, of which he is now a member emeritus, has extended over a period of 32 years. Dr. Avery still continues the work on which he embarked in 1913 when appointed to its staff to share in an investigation of pneumonia. According to the Association of American Physicians, of which he has long been a member, Dr. Avery's researches have stimulated a vast amount of work in various fields of bacteriology and infectious diseases. During this long period his work has been so rewarding that at present more is known about the life history and biochemistry of the pneumococcus than that of any other bacterium.

The alumni of the **Medical College of Virginia** held their annual banquet at the Hotel Statler, June 11. Among the speakers were Dr. L. F. Thomen, Dominican Secretary of State for Health and Public Service; Dr. William T. Sanger, President of the Medical College; Dr. Waverley R. Payne of Newport News, Va., President of the General Alumni Association; Dr. J. P. Gray, Dean of the College's Medical School; Dr. W. Henry Street of Richmond, Secretary of the General Alumni Association; and Mrs. Helen W. Seller of Richmond, Director of the alumni fund.

Dr. Frank Kreglow, President of the local alumni group, was toastmaster. Officers elected for the coming year were:

Dr. J. R. B. Hutchinson, *President*; Dr. Albert Alexander, *Vice President*; Dr. C. P. Ryland, *Secretary-Treasurer*.

At the **12th Annual Meeting of the American College of Chest Physicians** at the Sir Francis Drake Hotel, San Francisco, June 27–30, Drs. J. Winthrop Peabody, Brian B. Blades and Herman E. Hilleboe of Washington participated in the program. Dr. Peabody spoke on "Tuberculosis Sanatorium Standards" at the luncheon meeting, June 29, before a Conference of Medical Directors and Superintendents. He also participated in a Form on College Activities at a conference of College Chapter officials, June 28. Papers on "Mediastinal Tumors" by Dr. Blades and "An Objective Evaluation of the Radiography Used in Tuberculosis Case Finding" by Dr. Hilleboe were presented at the scientific sessions, June 30. Dr. Hilleboe also discussed "State and Local Problems in Tuberculosis Control" before a Conference of Tuberculosis Committees.

At the May meeting of the **George Martin Kober Society**, the fellowing officers were elected for the coming year:

Dr. Don S. Knowlton, *President*; Dr. Frank M. Hand, *Vice President*; Dr. Joseph L. Gilbert, *Secretary*; Dr. G. Victor Simpson, *Treasurer*.

DISTRICT OF COLUMBIA RHEUMATISM SOCIETY ORGANIZED

Present at the organization meeting of the District Rheumatism Society, held at the home of Dr. Darrell C. Crain on June 4, were: first row (left to right), Drs. C. H. McEnerney, H. R. Schreiber, B. J. Walsh, I. Levin; second row, Col. C. R. Mueller, W. J. Tobin, C. Berg, W. M. Yater; third row, G. Wyatt, Col. W. H. Graham, W. E. Clark, Gen. G. C. Beach; fourth row, J. Neviaser, D. W. Ingham, M. C. Cobey, T. Wiprud; standing, D. C. Crain, P. Hench.

The District of Columbia Rheumatism Society was organized by interested physicians who met for that purpose at the home of Dr. Darrell C. Crain, June 4. Dr. Crain was elected to serve as the first President, Dr. Charles H. McEnerney, as Vice President, and Dr. Milton C. Cobey, as Secretary-Treasurer.

The initial committees decided upon and those appointed to serve as chairmen were: Program, Dr. William Earl Clark; Organization, Dr. Custis Lee Hall; Membership, Dr. Henry R. Schreiber; Civic Affairs, Dr. Arthur C. Christie.

Present to address the guests was Dr. Philip Hench, Chief of the Arthritis Division of the Mayo Clinic. During the war Dr. Hench was Chief of Medicine in the Army-Navy General Hospital, Hot Springs, Arkansas.

At the recent meeting of the **American College of Physicians** in Philadelphia, Drs. Ernest Q. King and Henry Monat were elected to Fellowship in the College. Named to Associate membership were Drs. William K. Billingsley, Leslie H. Farber, Henry A. Grennan, Harold Stevens and Robert G. Taylor.

Dr. Charles Stanley White has been named to the **Board of Trustees of George Washington University** for a three-year term ending in 1949.

It was reported to the **Executive Board** at its meeting, May 27, that **Dr. Harry H. Kerr** had been appointed Chairman of the District of Columbia Cancer Society during the period of formal organization. In accord with Dr. Kerr's request for the appointment of two members of the Society as representatives to the District Cancer Society, the Executive Board named **Drs. William P. Herbst Jr., and Dr. Roger M. Choisser.**

The Washington Chapter of the Pan American Medical Association met at the Mayflower Hotel, May 28, to hear Mrs. Eunice Weaver of South America discuss her work on the rehabilitation of the leper in Brazil. The title of her talk was "The Sociological Aspects of Leprosy."

The new slate of officers for the Association is as follows:

Dr. Winfred Overholser, *President*; Dr. A. Barklie Coulter, *First Vice President*; Dr. Watson W. Eldridge, *Second Vice President*; Dr. Frederick A. Reuter, *Secretary*; Dr. Paul F. Dickens, *Treasurer*.

According to a recent press release issued by **George Washington University,** graduates of the School of Medicine, for the second consecutive year, passed all state and national examinations entered by them in 1945. Sixty-nine graduates were examined during 1945, 17 by state medical examining boards and 52 by the National Board of Examiners. Quoting the *Journal of the American Medical Association* the release states that of 4,928 graduates of approved medical schools in the United States who took the examination, 2.5 per cent failed. Of the 7,160 examined, including graduates of unapproved schools and of foreign schools, 8.4 per cent failed.

At the **94th Annual Meeting of the District Pharmaceutical Association,** which opened at the Mayflower Hotel, May 22, the following officers were installed: Leo F. Diegelman, President; Edwin O. Cockey, Paul Reznek and David Maxwell, Vice Presidents; Harold C. Kinner, Secretary; Roger Lusby, Treasurer.

The District of Columbia Dental Society, at its meeting, June 11, elected Dr. M. M. Alexander as its new President-elect; Dr. Robert M. Harper, Vice President; and Dr. Karl H. Wood, Secretary-Treasurer. Dr. Joseph A. Madden assumes the office of President for 1946–47.

Drs. John L. Parks and Preston A. McLendon were invited to lecture at the in-service training courses of the University of Michigan School of Public Health, June 5 and 6. Their lectures dealt with the relation of nutrition to maternal and child health.

Drs. Isadore Rodis, Robert H. Groh and Vasilios S. Lambros were named diplomates of the American Board of Neurology and Psychiatry following the May examinations.

Dr. Henry Monat delivered an address on "Problems in Gastroscopy" before the National Gastroenterological Convention in New York, June 21.

Dr. Howard F. Kane was made Professor Emeritus of Obstetrics and Gynecology at the graduation exercises of George Washington University, May 29.

Dr. John A. Swartwout, who attended the annual convention of the American Institute of Homeopathy in Detroit, June 9–13, read a paper before a meeting of the Surgical, Gynecological and Obstetrical Society of the Institute, June 11, on "Sodium Pentothal; Its Properties and Uses." **Dr. J. B. Gregg Custis,** who also attended the convention, presided at the SGO meeting as President of the Society.

Dr. Daniel L. Borden gave a dinner, May 27, at his home on Woodland Drive, in compliment to **Dr. William J. Mallory,** who retired from active practice on June 1, after having practiced in the District of Columbia since 1907. Dr. Mallory, who is Professor Emeritus of Medicine of George Washington University School of Medicine, has already moved to his country home at Lovettsville, in Loudoun County, Virginia. A few intimate physician-friends of Dr. Mallory were at the dinner.

Dr. Custis Lee Hall, President-elect of the U. S. Chapter of the International College of Surgeons, addressed the Wisconsin Chapter of the College, May 15, at the University Club of Milwaukee. The occasion was a testimonial dinner in honor of Dr. Thomas W. Nuzum, Janesville, Dr. William E. Ground, Superior, Dr. George Van Inger Brown, Milwaukee, and Dr. John M. Dodd, Ashland, all distinguished surgeons of Wisconsin and Fellows of the International College of Surgeons.

Mrs. William Archer Roberts, who retired as Executive Secretary of the **Council of Social Agencies of Washington and Vicinity,** July 1, was guest of honor at a tea at the Mayflower Hotel, June 7, attended by many of her associates and friends. In appreciation of her 24 years of service, she was presented with a silver bowl. Among those present was Theodore Wiprud, the Society's Secretary.

Major Ross E. Garrett, Director, Control Division, Office of the Surgeon General, addressed the Mid-West Hospital Association, which met in Kansas City, Missouri, April 25, on the topic, "Have We Planned Our Post-War Work—Can We Work Our Post-War Plans?" Major Garrett will be remembered by many members of the Society as the former Administrator of Health Security Administration, which office he held for many years.

Plans for a **$3,000,000 memorial hospital** to be built in Silver Spring, Md., as a memorial to the citizens of Montgomery County who gave their lives in World War II were announced, May 21, at the annual meeting of the Silver Spring Hospital Association, Inc., by Fred L. Lutes, President of the Association.

The hospital, which will contain service and treatment facilities for 400 or more patients when it is completed, will be built at Georgia Avenue and Forest Glen Road overlooking Sligo Park, on a 27-acre site which has been purchased for that purpose. The initial unit, estimated to cost about $1,000,000, will contain between 100 and 200 beds, depending upon the amount of funds raised in a forthcoming campaign.

Schenley Laboratories, Inc., inaugurated a new series of radio programs over the Columbia Broadcasting System on June 4 at 9:30 p.m., Eastern Daylight Saving Time. The half-hour program, known as "Encore Theater," will present radio dramatizations of famous films, novels, and biographies dealing with outstanding members of the medical profession as well as scientific achievements of the medical profession.

CORRESPONDENCE

Washington, D. C., June 12, 1946

Editor, Medical Annals of the District of Columbia
Washington, D. C.

Dear Sir:

I desire to call attention to a matter which should be of interest to doctors, nurses, and patients. The practical or undergraduate nurse situation is chaotic.

It is impossible to accurately estimate the number of persons occupied in practical nursing, but I think it is safe to say that there are upwards of one thousand in Washington. These people are not registered and are not licensed. Most employees who come in intimate contact with the public have to show evidence of knowledge of and of freedom from communicable disease. They are reëxamined yearly for this purpose. The practical nurse, who prepares food and serves it, who takes temperatures and bathes patients, is free to disseminate any disease she happens to have and is responsible to nobody. The demand for practical nurses is increasing, partly because of the scarcity of graduate nurses and partly because the income tax laws have so leveled wealth that it becomes a hardship for the average family to employ graduate nurses throughout protracted illnesses.

The graduate nurses are, of course, indispensable to the medical profession. Their skill and training make them invaluable in surgical operations, obstetrics, and in acute and dangerous illnesses. When the case is prolonged, however, and the nursing amounts to feeding, bathing, and general bodily care, the graduate nurse wastes her talents and is liable to be bored. The practical nurse fits in at this point, eases the financial strain on the family, and takes over the responsibility of the patient.

Practical nurses are registered and licensed in some of the states, notably, New York, Massachusetts, Connecticut, and Michigan. The practical nurses of Washington, D. C., obtain their employment through commercial agencies which charge them 10 per cent of their entire earnings. A number of them have blacklisted practical nurses who have joined an organization to demand registration and license and to improve and dignify their occupation. There are about seventy-five members in this organization who have employed a lawyer to prepare a bill for Congress for the regulation of practical nurses. This bill has been before the Commissioners for some time and is opposed by the commercial agencies and, strange to say, some of the members of the Graduate Nurses' Association. The bill provides that practical nurses who are now active should be registered if they can prove satisfactory service during the last two years. All others will have to show that they have taken a one-year course in the fundamentals of nursing and pass an examination in order to be registered.

Those of us who practiced in Washington during the war know the fine work done by the Red Cross Nurse's Aides who became very efficient after a short course of instruction and who obtained their experience under the graduate nurses at the hospitals. (Several hospitals in Washington at this time allow practical nurses to attend patients under the supervision of the nursing staff.)

I hope that the Medical Society of the District of Columbia will endorse the Practical Nurses' Association in its aims toward betterment of service to the community. I recommend that the Hospital Association of Superintendents will give this matter careful consideration and offer a one-year course of training at the hospitals for practical nurses. Many girls apply to hospitals for the graduate nurses' training course who are unable to fulfill all of the requirements for such a student nurse. These persons would make good material for the practical nurses' course.

The public demands the practical nurse for protracted illness, and we, as physicians, should demand that practical nurses have enough fundamental training to insure safety for our patients.

Very truly yours,
James A. Gannon, M.D., F.A.C.S.

BOOK REVIEW

Men Without Guns. De Witt Mackenzie, War Analyst of the Associated Press. Descriptive captions by Major Clarence Worden, Medical Department, U. S. Army; foreword by Major General Norman T. Kirk, Surgeon General, U. S. Army. Price, $5.00. Pp. 152, with 177 drawings, including 118 plates in full color by famous contemporary artists. Philadelphia: Blakiston, 1945.

Major General Norman T. Kirk, in his Foreword, aptly describes the Abbott collection of paintings as "a priceless archival treasure." Those who saw the original collection of paintings while on exhibit at the Corcoran Art Gallery in Washington and who have read Mackenzie's account of the remarkable role played by the Army Medical Corps during World War II can well appreciate that description. Unless a service physician prefers few reminders of his war experiences, it seems that he would value a copy of this book as an almost priceless memento of World War II.

The project itself was the inspiration of Lt. Colonel Howard F. Baer, M.A.C. Sponsor of the costly undertaking was Abbott Laboratories—another example of those philanthropic enterprises which we have come to accept rather complacently from the large pharmaceutical supply houses in this country. The text and the illustrations, reproduced in their original color, cover all phases of medical warfare, from the laboratories of Camp White, Oregon, to open-air surgery in the Burma jungle, and then the long road back by way of physical and occupational therapy.

By introducing the twelve artists commissioned to do their task "on the scene," and by naming the theatres to which they were assigned, the vast scope of this project can best be presented: Howard Baer, Burma-India-China; Robert Benney, Western Pacific; Peter Blume, Halloran General Hospital, Staten Island, New York; Franklin Boggs, Southwest Pacific; Francis Criss, Army Medical Center, Washington; John Steuart Curry, Camp Barkeley, Texas; Ernest Fiene, plants of medical industry on the home front; Marion Greenwood, England General Hospital, Atlantic City, N. J.; Joseph Hirsch, Italy; Fred Shane, Carlisle Barracks, Pa.; Lawrence Beall Smith, England and France; Manuel Tolegian, Army Nurse Corps training school at Camp White, Oregon.

After some explanatory notes in each chapter, the author lets the artist tell his own story. Thus the whole book has a first-hand flavor which is intensely dramatic. The brief, pithy chapter titles too speak volumes—to mention a few—Southwest Pacific, Saipan, Italy, D-Day in Normandy, Burma Road. These well remembered battle areas were the actual scenes for the preliminary sketches. The paintings, superb in concept and execution, are a lasting tribute to the magnificent performance of the Army Medical Corps, with generous emphasis on the part played by the medical corpsman and the Army Nurse Corps.

A. L. E.

REPRINTS RECEIVED

The following reprints have recently been received, for which due acknowledgement is made.

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"Medical Care for the American People." Louis H. Bauer. Journal of the American Medical Association, December 1, 1945.

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"Medico-Chi and the National Selective Service." W. Montague Cobb. Journal of The National Medical Association, November 1945.

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"Studies in Connection with the Selection of a Satisfactory Culture Medium for Bacterial Air Sampling." Roy Schneiter, John E. Dunn and Barbara H. Caminita. Public Health Reports, July 13, 1945.

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"The Rorschach Analysis in the Treatment of Alcoholism." Robert V. Seliger and Victoria Cranford. Medical Record, January 1945.

"The Role of Psychiatry in Alcoholism." Robert V. Seliger and Victoria Cranford. Virginia Medical Monthly, April 1944.

"A Medical Study of the Effect of TNT on Workers in a Bomb and Shell Loading Plant," Rudolph F. Sievers, Alfred H. Lawton, Folke Skoog, Paul A. Neal and W. F. Von Oettingen; "Report of Fatal Case of Aplastic Anemia," Robert L. Stump, A. Ralph Monaco and Rudolph F. Sievers. Washington: U. S. Government Printing Office, 1945.

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"Thiouracil in the Control of Thyrotoxicosis." E. M. Watson. The Journal of Clinical Endocrinology, July–August 1945.

"An Outbreak of *Salmonella* Infection in Man from Infected Chicken Eggs." James Watt. Public Health Reports, July 20, 1945.

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JAMES FRANKLIN DOUGLAS, M.D.

(1864–1946)

Dr. James F. Douglas, retired physician and a Life Member of the Medical Society of the District of Columbia, died May 21 at Emergency Hospital following a brief illness. He resided at 1209 Floral Street, N. W.

A native Washingtonian, born December 7, 1864, Dr. Douglas was educated in the public schools of the District of Columbia and graduated from Columbian Medical College in 1892. He practiced on Capitol Hill for a quarter of a century before joining the United States Public Health Service as a Major during World War I. After the war he served for 15 years with the Veterans Administration as a member of the Medical Board of Appeals. He retired in 1936.

Dr. Douglas was elected to membership in the Medical Association of the District of Columbia in 1905, and became a Life Member of the Medical Society on January 1 of this year. He was also a member of the American Medical Association, the Sons of the American Revolution, the Masonic

Veterans' Association and the St. Alban's Episcopal Church.

His wife, Mrs. Emma F. Douglas, preceded him in death several years ago. Surviving are a son, James Franklin Douglas, Jr., and a daughter, Mrs. Ralph F. Thompson, both residents of Washington, and three grandchildren.

Orthopedic Surgery—Lloyd

(*Continued from page 314*)

in spite of the fact that it has been present for 15 years.

Several different writers have reported the use of a bone graft between the bodies of the vertebrae to obtain spinal fusion. The graft is inserted from a posterior wound, such as one uses in a laminectomy. Such a procedure is contraindicated in cases in which there is any sort of inflammatory disease of the vertebral bodies, but in cases in which the disability is due solely to mechanical factors this procedure is actually more sound mechanically than the conventional fusion.

There is increasing use of cancellous bone chips as opposed to massive, cortical grafts in bone surgery. The small chip grafts unite more more rapidly and more surely to form solid, new bone.

Much could and should be said concerning the confusion which exists in the minds of the profession in general with regard to the relative merits of the various arguments which one has heard in recent years whenever the subject of poliomyelitis is brought up. It is hoped that a paper upon this subject will be accepted for publication in the near future.

A few conditions in orthopedic surgery have been discussed briefly with regard to recent advances and present status. It is hoped that this general review will assist the overworked and overread general practitioner to keep abreast of management of the more commonly encountered orthopedic conditions without the necessity of voluminous reading in a special field.

Grateful acknowledgment is made for inspiration and encouragement from Dr. Charles Stanley White and Dr. Duane Richtmeyer.

Penicillin—Hirsh

(*Continued from page 319*)

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Footnotes—Observer

(*Continued from page 342*)

"come of age." There is no doubt that this agreeable, energetic man will give his best to a very big job. "Best wishes, Tommy!". . . . "A quick vacation with a clear conscience." Thus the *Journal of the Medical Society of New Jersey* recently characterized the Society's forthcoming annual meeting at Atlantic City. This apt description might well be applied by the Committee on Arrangements for the 17th ANNUAL SCIENTIFIC ASSEMBLY to be held September 30, October 1 and 2. It is really very much to the point and true. . . . The Woman's Auxiliary of the Kentucky State Medical Association sponsors an Annual Doctor's Day. Usually it presents a program memorializing a deceased Kentucky physician whose achievements have been outstanding. This year, Dr. Irving Abell, former President of the AMA and a veteran of World War I, and Dr. Glen Spurling, a veteran of World War II, spoke on Kentucky's contribution in medical services to our soldiers, and paid special tribute to those physicians who made the fullest sacrifice. Their talks were broadcast over Station WHAS . . . . If he remembers correctly, your Observer has commented before on the excellence of some state medical journals. In this select company is the *Wisconsin Medical Journal.* One of its outstanding features is "The Medical Forum," a newsy, informative department which contains all the latest, up-to-the-minute news on the social and economic problems of medicine. The *Journal* is to be commended on this distinctive and worthwhile feature. . . . Quite a few of our members know that Dr. William C. Woodward, formerly Director of the Department of Legal Medicine and Legislation of the AMA, now resides in Washington. He moved here following his retirement and is often seen by his friends. He still retains his vigor and a keen interest in medical affairs. Your Observer was therefore not surprised to read a communication in "Letters to the Editor" of the *Washington Post* from Dr. Woodward in which he discussed the use and misuse of the term "mental illness." Dr. H. E. McGregor of Washington, a physician unknown to your Observer, replied a few days later, his letter appearing in the same newspaper. Taking Dr. Woodward to task for his views, he said, "It is possible that he is not well informed as to existing conditions, or perhaps he is a student blindly accepting what others tell him and he is willing to go along with the crowd even in the wrong direction." No one will appreciate the humor of that statement more than Dr. Woodward. By the way, Dr. Woodward failed to indicate in signing his letter that he was a physician. Consequently, Dr. McGregor refers to him as "Mr. William C. Woodward."

T. W.

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TREATMENT IN PSYCHIATRY*

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THE problem of treatment for the mentally ill in the world today is of such magnitude that it almost fails of comprehension. We hear it repeated that there are more patients in mental hospitals than in all other hospitals combined and that this total is growing each year. Such statements are true but this increase may not be entirely due to greater incidence but to lack of resistance to admission on the part of the patient and his family in their growing knowledge of mental hygiene and psychiatric therapy. Primarily it seems due to the increase in life span in general with its resultant increase in mental illness in the higher age group. The strains of modern war brought home to us again the effect of environmental stress on the personality structure and of the vulnerability of such large numbers of our people to mental illness. It is estimated that each psychiatric casualty in the armed forces will cost the Government thirty thousand dollars. Investigation reveals that over one hundred thousand new patients are admitted to mental hospitals each year and that in the United States alone some one billion dollars is invested in the physical structure of mental hospitals. But this is not the whole story. General medical men in outpatient clinics in our general hospitals estimate that from 40 to 60 per cent of their patients who seek medical attention suffer from emotional disturbances rather than from organic disease, even though the symptoms may be expressed as physical complaints. To most of these patients no psychiatric treatment can be made available except through psychiatric-minded diagnosticians.

In view of these facts some physicians feel rather pessimistic about the whole problem and tend to believe that hospitalization for care and protection of our mentally ill is about all that can be provided. Unfortunately, in some states there are waiting lists for admission to state hospitals even though some of these same institutions are only staffed and equipped for care rather than for treatment. Progress in psychiatric therapy must of necessity be slow and laborious, not only from the scientific standpoint but also in the education of the public to the necessity of providing funds for adequate equipment and well trained psychiatric staffs. Some of our states have provided only fifty cents a day per patient for state mental hospitalization. Not even a jail could function on this pittance! Notwithstanding such facts, much progress has been made in the study and treatment of mental illness since the turn of the century and additional progress will probably be more rapid. This new knowledge applies both to mental illness which is primarily due to organic or physiogenic etiology as well as to that which is primarily psychogenic in origin. Much knowledge is also collected and disseminated about the large group of symptoms included in the term psychosomatic disorders and this in turn has aroused much interest in other aspects of psychiatry by many physicians as well as laymen. This arousal of interest augurs well for still further advances in psychiatry and provides hope that the eventual solution of means as well as method of therapy may be in the making in the not too distant future.

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It is a difficult problem to sum up our present knowledge of treatment in psychiatry in any concise way and even more difficult in a single lecture period. No attempt or claim will be made for completeness, many statements must perforce be brief and often incomplete, and generalities will be frequently expressed. For details you are referred to the many excellent reports in our modern psychiatric literature, as well as to the works of such physicians as Bernheim, Charcot, Janet, Freud, Bleuler, Jung, Adler and Kraepelin.

In this presentation no attempt will be made to discuss such psychopathic conditions as mental deficiency, alcoholism, epilepsy, drug addiction and psychopathic personality. Attention will be directed primarily to therapy of the common mental illnesses, the physiogenic psychoses, the psychogenic psychoses, and the psychoneuroses.

The Physiogenic Psychoses

In the physiogenic psychoses the primary disturbance seems to be a diffuse pathology in the cortex of the brain due to toxins, infection, degeneration or trauma. The mental symptoms are usually those of organic syndrome, memory defect, disorientation, impaired judgment and possible character and emotional change. Some of these conditions are reversible, such as delirium tremens, while others are irreversible, such as senile psychosis and post-traumatic personality deterioration.

Pollock reports that of the first admissions to Massachusetts mental hospitals from 1917 to 1933, psychosis with cerebral arteriosclerosis was responsible for 11.3 per cent, alcoholic psychosis 8 per cent, senile psychosis 7.2 per cent, general paresis 6 per cent, and other somatic diseases 3.4 per cent. The total percentage of these diseases equaled 35.9 per cent. In comparison the two major psychogenic psychoses with greater incidence were dementia precox with 19.4 per cent and manic-depressive with 9.6 per cent—a total of 29 per cent of all first admissions.

The treatment of the toxic psychoses will depend on the specific etiologic agent. The usual medical treatment is instituted, special efforts are made to reduce the fever, to keep up caloric and fluid intake, to promote elimination and to bolster possible vitamin deficiency. Sedation with the less toxic drugs may be necessary but should be cautiously used. Morphine, paraldehyde or sodium amytal given intravenously are usually most effective. Sponge baths, continuous flow tub baths or cool wet packs may be helpful as sedative measures.

The treatment of the psychoses due to infection of the brain will obviously depend on the specific etiology. Syphilis is most often responsible. Treatment of general paresis consists primarily of the administration of therapeutic malaria followed by chemotherapy with bismuth or the arsenicals. The patient is allowed to have from 12 to 15 therapeutic malarial paroxysms with fever of 103 to 105° F. Similar elevations of fever by physical means, such as hyperthermy, is claimed by some to be beneficial, but this type of treatment has much to be criticized. The long period necessary for each treatment, the personnel time required, the increased danger to the patient, and the difficulty in controlling the fever all militate against its use in most hospitals. Penicillin in the treatment of syphilis of the central nervous system is now in the experimental stage but gives promise of fairly good results. The administration of typhoid vaccine for general paresis was tried by a number of clinics with varying success. In our experience this treatment is not as efficacious as malarial therapy. It may well be that the elevation of temperature is only one of several factors dealing with the biologic response of the body to the malarial process. With therapeutic malaria followed by chemotherapy we find that approximately one third of our paretics recover, one third are improved, and one third are unimproved.

The most frequent physiogenic psychoses due to chronic degeneration are senile psychosis and psychosis with cerebral arteriosclerosis. These make up about 18.5 per cent of first admissions to mental hospitals. In the former condition there is no specific treatment, although excellent nursing care, without doubt, prolongs the life of the patient with senile psychosis. This is shown by the marked decrease in the number of deaths in such cases in a first class mental hospital as compared to the hospital where little attention is paid to such details. In psychosis with cerebral arteriosclerosis attention to accessory physical defects, together with efforts to control elevated blood pressure and to diminish physical overactivity may be beneficial. Some recent studies seem to indicate that patients showing evidence of greatest arterial calcification are less prone to develop accompanying mental symptoms. In patients with traumatic psychosis the damaged cortical tissue does not regenerate, but treatment, through reducing intracranial pressure and removing depressions of bone and blood cysts, may be helpful.

In the treatment of these organic conditions we must always remember that we are dealing with the whole organism, not just treating the malfunction of any single organ. Tactfulness, sincerity and a sympathetic approach are quite often the keys to successful physician-patient relationship leading to good adjustment and contentment thereafter.

THE PSYCHOGENIC PSYCHOSES AND THE PSYCHONEUROSES

The name psychogenic psychoses is given to those psychotic states in which no principal physiogenic etiology can be found. These might be called nonorganic psychoses. Principal members of this group are schizophrenia, paranoia, and manic-depressive psychosis. In Massachusetts Pollock reports that from 1917 to 1933 dementia precox accounted for 19.4 per cent of the first admissions, manic-depressive psychosis 9.6 per cent, and paranoia 2 per cent. The condition labeled psychoneurosis is much more prevalent, although very few patients with this disorder are admitted to public hospitals for treatment. Most such patients are treated by the general practitioner or in medical outpatient clinics. Only a few with the most severe symptoms ever get to a psychiatrist for treatment. This situation makes it all the more important that psychiatry should be a major subject in our medical curriculum and that information concerning modern methods of treatment should be as widely disseminated to physicians as possible. Three possible causes of these conditions have been considered to be: (1) undetermined physiogenic etiology, (2) disturbance in a semi-independent or independent psyche, and (3) disturbance in the personality adjustment from possible hereditary, constitutional and/or environmental factors. These could be called the structural organic, the psychic and the psychobiologic theories. Each psychiatrist must decide which approach to the understanding of such disorders he will use, for his treatment method will obviously depend on such decision. To the writer an attempt to insist on a physiogenic cause even when no conclusive evidence can be shown, stifles the psychiatrist in treatment method and in personal understanding of the patient's problems. Such concept also makes for cataloguing of patient's ills into indefinite organic groups which then seem to indicate the necessity of medicinal or surgical intervention when actually none is necessary. The concept of a semi-independent psyche which functions apart from the body certainly appears lacking in practical judgment and promotes confusion in the minds of many physicians. This concept apparently is going out of style at present.

The concept that personality disturbances are due to failing adaptation of the whole individual by reason of hereditary, constitutional or environmental factors has rapidly gained adherents since the turn of the century. With some qualifications such concepts comprise the American school of psychiatry, psychobiology, or the eclectic method. Emphasis is placed on the nonstatic, everchanging, dynamic human functioning. Such concept is practical, commonsense, broad in scope, emphasizes mind-body interrelationships, explains psychosomatic symptom formation, indicates the treatment approach and at the same time does not lose track of the importance of physiogenic factors which may be present. Certainly this theory has much to recommend it.

Treatment procedures in the psychogenic psychoses and psychoneuroses are many and varied but those most widely accepted can be placed in two divisions:

I. Psychotherapy
II. Physical methods of therapy.

Psychotherapy

Psychotherapy utilizes many methods, including:

1. Suggestion and hypnosis
2. Persuasion, reasoning and authoritative direction
3. Bibliotherapy and self-analysis
4. Psychodrama
5. Psychoanalysis.

There have been differences of opinion concerning the correct definition of the term psychotherapy. Some psychiatrists believe that they are using psychotherapy if they stop for a few minutes on ward rounds to listen to the patient's complaints and then leave him after some slight word of encouragement. Kubie has said that "In this loose sense, psychotherapy embraces any effort to influence human thought or feeling or conduct, by precept or by example, by wit or humor, by exhortation or appeals to reason, by distraction or diversion, by rewards or punishments, by charity or social service, by education, or by the contagion of another's spirits . . . It will be our thesis that as a science psychotherapy begins only where these leave off." In general, it can be said that psychotherapy aims to change the personality organization and function of the individual who suffers by reason of the lack of good personality integration. It is now commonly accepted that strong psychologic forces are constantly being felt by each individual in his daily life adjustment and that these are of such character that some are recognized while many are unrecognized by him. The science of psychotherapy has been developed to uncover the unrecognized forces which are sometimes spoken of as the unconscious forces. It also seems clear that the conscious forces are constantly changing as an equilibrium is attempted in the adjustment with the environment. By psychotherapy we may modify the personality organization of the patient so that the individual will be more tolerant of himself and others. The factors of conscience will be less critical, anxiety will diminish, and the entire personality will assume a better balance. Such are the true aims of psychotherapy. Full attainment in this regard cannot always be reached, and one must be satisfied with partial success through palliative rather than curative measures.

The environmental and interpersonal difficulties are often fairly easily modified through the efforts of the understanding physician who knows his patient as well as the family constellation. The changing of attitudes of members of the family, free, frank discussion of the problem with patient and family, practical assistance of social agencies and referral of religious problems to a psychiatrically trained minister are methods open to every physician. Practical instruction in general medical and mental hygiene may also alleviate much tension, worry and anxiety. We, as physicians, cannot change the basic way of life of society nor can we provide for the needy, relieve financial distress, run a marriage bureau, or in other ways settle all the ills of the world. There are many life situations which cannot be changed or altered, but we always have the hope that the personality of the affected individual can be altered so that the rigidity and narrow range of adjustment may be eased and expanded.

The individual method of psychotherapeutic approach used by the physician must depend on the factors of importance uncovered in the life history of the patient, as well as an understanding of the therapeutic technic best suited to the therapist. Most psychiatrists emphasize the importance of suggestion in the therapeutic situation, and such importance is obvious. The patient comes to the physician expecting relief for his symptoms, whether they be physically or emotionally determined. A favorable therapeutic situation is already provided. If the therapist handles himself in such a manner that he instills further confidence and security in the patient the suggestions which he makes will have a strong influence on the patient and such influence can be used to direct the patient's energies and thoughts from his symptoms to more wholesome accomplishments and goals. In this way anxiety is relieved and a tendency toward general calm and pleasant living is provided. Utilizing the power of suggestion, some psychiatrists place patients in the hypnotic trance which is an extremely suggestible state. There has been some hesitancy on the part of psychiatrists to use this treatment because of its ill repute due to its use by charlatans and quacks. As a treatment method hypnosis is somewhat limited in scope, but in recent years it seems to have given very favorable results in especially selected cases.

Persuasion and reasoning are both valuable tools in the hands of the understanding physician. A patient can recover when it is shown to his satisfaction that there is no adequate physical or emotional reason why he should continue disabled. In some patients this happy result is never attained through reason or persuasion, and other methods must be tried.

Authoritative direction is another tool which is valuable in some cases. The physician in a calm, confident, authoritative manner directs the patient to accept his solution of the problem. This is successful in some cases, but when it is not successful the physician may feel frustrated and accuse the patient of lack of coöperation and the like, and thus an additional interpersonal problem is added.

Bibliotherapy as a method of treatment has been used quite successfully in some cases for a great many years. Selected reading is assigned by the psychiatrist to emphasize the matter under discussion as well as to give the patient a chance to learn more of the primary factors entering into personality function on which the therapist does not have time to elaborate. By some psychiatrists this reading is assigned in accordance with the simplicity of the subject matter, the reading becoming more advanced as the treatment continues. This enables the patient to do a mild amount of self-analysis under such guidance. The patient is rather often impressed with the assigned reading matter, since somehow that which is read seems true, if made as a positive statement. Bibliotherapy without the guidance of the therapist is not of much value and often produces more superficial emotional disturbance in the patient. Self-analysis can be quite helpful if also done under guidance. Such analysis in the presence of depression will, of course, be colored by this emotional factor, and if done in the presence of elation the same difficulty is encountered. It is certainly valuable to estimate truthfully and factually one's assets and liabilities in personality organization, in so far as possible. No one can deny that through self-control and will a person can guide his own actions and emotions into more healthy channels. Too much attention directed to self-analysis can be harmful, since the individual tends toward egocentricity and possible hypochondriasis.

Psychodrama is a fairly recent technic of treatment which has proved beneficial in some cases. It utilizes a dramatic stage with a psychiatrically trained director. The technic in its simplest form consists of the spontaneous acting out of certain interpersonal relationship scenes, the cues for which have been found in the life history of the patient. The scene is outlined by the director, the patient is assigned a character (either himself or another person) and the other roles are assigned to trained personnel on the psychodrama staff. As the action of the scene proceeds spontaneously, the patient himself will often gain a very objective viewpoint of his own real place in his actual life situation which he would otherwise not easily attain. If a patient has had much difficulty with one of his parents and in a psychodrama scene he plays the part of this parent, the result may be that he gains tolerance and understanding of this parent. This type of treatment has its limitations, but it is now accepted by a number of clinics as a recognized type of psychotherapy which is sometimes included under the general term of group psychotherapy.

Psychoanalysis

Sigmund Freud, who studied under Charcot and Bernheim and collaborated with Breuer, is considered the father of psychoanalysis. Freud and Breuer first used hypnosis in the treatment of hysteria in an effort to bring to consciousness the memories of traumatic emotional events together with the pent-up emotion attached thereto. These responses were called abreaction and catharsis. Since hypnosis had its limations, however, Freud began to have the patients, in full consciousness, talk freely of anything which occurred to them. He reported that they soon began to speak of special events dealing with their traumatic experiences. This was the beginning of the use of free association. As the work proceeded Freud formulated the theory of the unconscious. This formulation is expressed by I. Wechsler as follows: "The unconscious as understood by Freud is not merely a repository of old or forgotten memories and impressions which can be recalled at will or revived in hypnosis nor the mystic universal force as stated by both Nietzsche and Schopenhauer and more recently expounded by Jung. It is conceived of as a living, motivating, dynamic system of mental processes, constituting the major part of psychic life, capable of independent existence within the individual, and exerting preponderant influence on his behavior. . . The unconscious, not having to deal directly with objective facts of the outer world as does consciousness, is not subject to limitations imposed by reality . . . Finally, the unconscious does not reckon with reality because it is guided by the pain-pleasure principle."

Freud found that sex was very frequently spoken of by the patients and that dreams appeared to be related to the patient's actual life problems as well as to symptoms and past emotional experiences. Dream analysis, therefore, became a major function in psychoanalysis.

In the classical analysis the patient reclines on a couch in a quiet darkened room away from extraneous sounds and noises. The analyst sits behind the patient. The patient is told to talk of anything that comes to his mind, no matter what this may be. Thoughts, feelings and desires are said to recur with great frequency and in various sequences and connections. Such recounting of experiences in the presence of the analyst acts to relieve the patient by this acting out or abreaction and is said to permit the patient to master these disturbing repressions. The analyst usually remains quite passive during these sessions which classically are of about 50 minutes' duration, six days a week. There is no limit to the length of an analysis, since this depends on the individual case. The primary factors in the theory of psychoanalysis include (1) the concept of the unconscious, (2) the concept of repression of early traumatic sexual experiences, and (3) the use of free association and interpretation of dreams as therapy. A special language has been developed dealing with psychoanalytic concepts which is rather involved and often criticized. The psychoanalytic technic is a special one, although there have now developed many variations from that originated by Freud. It is used primarily in the psychoneuroses but has a limited use in the psychoses. Some usual contraindications are physiogenic mental disorders, psychopathic personality or constitutional character disorders, and chronological age over 50 years. Psychoanalysis has had its share of criticism through the years but has in general weathered the storm fairly well.

Physical Methods of Therapy

Physical methods of therapy include the following:

1. Rest treatment
2. Recreation therapy
3. Occupational therapy
4. Hydrotherapy
5. Cryotherapy
6. Narcotherapy
7. Prefrontal lobotomy (psychosurgery)
8. Insulin shock and subshock insulin
9. Electroshock.

Physical methods of therapy may be used alone or in conjunction with psychotherapy. The essential factors of each case will determine the type or types of therapy to be used. Some forms of physical therapy and psychotherapy have been used for hundreds of years.

Rest Treatment

At the end of the last century the rest cure as outlined by Weir-Mitchell became widely accepted in the therapy of the mentally ill. He advocated complete rest in bed with adequate nutrition in the form of frequent feedings, and massage and electricity were usually included in the total treatment. The factors of weight, fat and blood were thought by Weir-Mitchell to be of unusual importance for recovery. The influence of Weir-Mitchell's personality on his patients was perhaps a primary factor in the success of this treatment, since many other physicians have failed to get similar results. The treatment has lost most of its popularity as the dynamics of mental illness have become more clear. We now know that fatigue due to emotional tension or conflict is not cured by rest and that rest may even exaggerate the symptom. Many physicians now advocate as little rest in bed as possible except for the purposes of normal sleep, and such recommendations include the period of postmedical or postoperative recovery. Overwork as a cause of mental illness has been extremely exaggerated and actually but few illnesses can be attributed to this cause. It is still used in rationalization very frequently by both patients and relatives but actually is a common misconception concerning mental illness.

The main indication for rest treatment is in the case of a patient who is extremely excited, restless, overactive and exhilarated, who feels no fatigue and therefore is in danger of physical exhaustion. Such rest is usually best provided through sedative hydrotherapy or chemical sedation.

Recreation Therapy

Adequate recreational interests are necessary for good physical and mental health. In many individuals suffering from mental illness self-criticism, lack of confidence, and withdrawal from usual recreational interests are quite common. It becomes the duty of the psychiatric hospital to supply facilities for recreation, and most hospitals respond by supplying as many different types of recreation as possible. To the acutely ill patient are brought card games, dominoes, shuffleboard, rubber quoits, checkers and ping pong. As the patient improves, movies are brought to the wards, group dancing and ballroom dancing are encouraged and, in addition, special orchestral and vocal musical programs are provided. Small pianos are moved from ward to ward for the use of individual patients, and music lessons on different instruments are often provided by volunteer workers. Group singing, as well as solo work, is encouraged. A full recreation program can and should be provided in all modern mental hospitals.

For the convalescent patients who are athletically inclined, recreation in the form of volley ball, tennis, soft ball, baseball, archery and golf furnishes many pleasurable hours and assists in the transition from hospital to home.

Occupational Therapy

Occupational therapy has been used in the treatment of mental disease for several thousand years. Its value was recognized by both ancient and modern medical men. Since the beginning of the present century much impetus has been given to this form of treatment and particularly during the war just ended. Occupational therapy became a major part of the whole rehabilitation program in the armed forces. In a large mental hospital the acute cases as well as the chronic are benefited by occupational therapy whether it be administered as habit training, preindustrial shop work, or in one of the more limited but special fields such as metal work, sculpturing or ceramics. The psychologic needs of the patients are given primary consideration in the selection of suitable occupational work assignment which is made by the patient's own physician in the form of a prescription. Occupational therapy stimulates the return of confidence, since it represents practical work accomplished, diverts attention from inner emotional conflicts, helps to relieve tension, and assists in preventing rut formation with final regression and dilapidation of personality, so often seen in a patient with chronic mental illness.

The therapy is administered and guided by trained occupational therapists under the supervision of psychiatrists. Industrial shops are organized for the making of such articles as brooms, mops, shoes, towels and similar articles. The arts and crafts are supervised in separate occupational therapy sections in the different hospital buildings, and, in addition, the simpler forms of occupational therapy, such as belt making, basketry and leather work are made available to the more acutely ill patients on the individual wards. In some of the armed forces' rehabilitation centers occupational therapy in the form of the assembling of various types of engines and other machinery has been of unusual interest to such patients and in some instances enough training has been provided to enable the patient to secure like employment in civilian life.

Hydrotherapy

In the era of Hippocrates baths were used for mental patients, and some form of treatment by the use of water has been used ever since. There are a number of individual methods of hydrotherapy, but these methods are primarily used for either sedation or stimulation.

For sedation the most common form of hydrotherapy is the continuous neutral bath. For this purpose a large tub about 78 inches long and 20 inches deep, equipped with a hammock which supports the patient in the water, is used. Water at 94 to 96° F. flows into the tub at one end and empties from the other end, and the temperature and flow of both are maintained by an especially constructed apparatus. The length of such continuous bath may be extended from 1 to 2 hours or longer, and in most cases the sedative value is obvious. The patient often falls asleep during the treatment even though he may have been previously excited, restless and overactive. Contraindications are extreme debility and pulmonary tuberculosis. The constant supervision of a trained attendant is absolutely necessary.

The wet sheet pack is also a valuable sedative measure but somewhat more dangerous than the continuous bath by reason of the possibility of collapse or heat stroke if the patient is not carefully observed. Such wet pack is usually given on an especially selected pack table, about 30 inches high, rather than on a bed. A thin mattress is placed on the table and this is covered by a rubber sheet. The patient is wrapped in sheets which have been wrung out in water of about 60 to 70° F. If a patient is debilitated the temperature of the water should be increased to 90 or 95° F. Following the application of the cold wet sheets, which cover the patient from neck to feet, blankets are then quickly individually wrapped around the patient in the same way so that no air pockets remain. An ice bag should be applied to the head. Care is taken to prevent the patient from rolling from the table, and pulse and respiration are both carefully watched for indications of difficulty. Such a pack may be continued for periods of from 1 to 4 hours. Some physicians believe that if the patient does not react well and show evidence of sedation at the end of 1 hour the procedure of repacking the patient should be carried out.

Hydrotherapy which is stimulating utilizes the short application of cool water to the body in one of several ways. Such stimulative therapy is particularly useful in apathetic, retarded or depressed states. Application of cool water is usually made with the use of needle or shower sprays and the Scotch douche in which two alternating streams of water under pressure, one hot and one cold, are played on the spine, under the arms, and on the legs. All these types are quite invigorating and tend to drive the blood from the peripheral circulation, which is the reverse physiologic action to that seen in the continuous bath and cold wet pack.

Other types of therapy with water are saline baths, salt glow and friction rub, affusions and whirlpool baths, but these methods are not now widely used.

Treatment with the fever cabinet has already been mentioned and has no value in the treatment of psychogenic disorders.

CRYOTHERAPY

Cryotherapy or production of very low body temperature is still in the experimental stage at the present time. It is being tried in about the same indications as electroshock. This refrigeration method has not been proved to be of definite value yet. Lowering of body temperature to 74.6° F. with survival of the patient has been reported.

NARCOTHERAPY

Narcotherapy is a general term which includes treatment by means of short or extended periods of sleep induced by drugs. Various anesthetics and hypnotic drugs have been used for many years in treating the mentally ill. Such drugs include bromides, trional, ether, alcohol, scopolamine, paraldehyde, chloroform, morphine and others. With the development of the newer barbiturates, nembutal, evipal, sodium amytal and sodium pentothal were found to be excellent drugs for this purpose. Bleckwenn, in America, and J. S. Horsley, in England, began working with the barbiturates in 1929 or 1930 without knowledge of each other's work. Following their reports a number of workers in the field began using this method. Gradually two technics of treatment with intravenous barbiturates evolved. The first of these, prolonged narcosis, consisted in keeping the patient asleep for about 20 hours each day for a period of from 5 to 20 days. Twice daily, a.m. and p.m., the patient was permitted to awake, and at such periods it was frequently noted that the patient would be much less confused and would be able to discuss his problems with the physician in a more rational manner. From this lead the second method, temporary narcosis, evolved. This method consisted in giving the patient small doses of intravenous barbiturate, not sufficient to produce deep sleep, but in the period between sleep and full consciousness the patient was found to be quite suggestible, often lost his inhibitions, and in this state was able to bring out clearly emotional conflicts which may have been repressed in the ordinary waking state. At Saint Elizabeths Hospital we have used both methods of therapy, but temporary narcosis has been used more frequently for the reasons that it is simpler and easier, requires less time and personnel, complications are almost entirely absent, and we see a greater number of patients in which this therapy is indicated.

The technic of temporary narcosis is relatively simple. While in bed in a quiet, semi-darkened room, the patient is given a 5 per cent solution of sodium amytal by vein, at the rate of about 1 c.c. per minute. In the mute or stuporous patient we watch for flushing of the face, opening of the eyes, moistening of the lips, or signs of restlessness. At this stage the patient has usually received from 2 to 6 grains of the drug. Attempts are then made to rouse the patient by speaking to him quietly but authoritatively, and he will usually begin to respond slowly to simple questions. He is then led into a discussion of his personal difficulties, and very frequently with the loss of inhibition much repressed material will be revealed. If no response is obtained, a small additional amount of the drug is injected and stimulation to talk is again made. In the Tunisian campaign Grinker and Spiegel used sodium pentothal and found that in the acute traumatic neuroses of war the patients reënacted the traumatic emotional experiences with much release of repressed emotion. This process was called abreaction, and with the administering of psychotherapy the entire process was called narcosynthesis. Horsley called his particular method of therapy narcoanalysis, and he principally used nembutal as the drug of choice. Other conditions treated by temporary narcosis include the severe anxiety states, the retarded depressions and conversion hysteria, with or without amnesia. This treatment can be a very valuable therapeutic tool when used with psychotherapy. When used alone it is of no particular value.

Continued narcosis was tried by several workers in treating the acute psychoses in war, and, although some success was reported, other workers felt that the treatment was of little value. In civilian practice it is now usually limited to patients who show acute mental and physical excitement and who quickly suffer from exhaustion. The treatment will give the patient rest and sleep, and the psychiatric nursing problem is made much simpler. In our experience we have had difficulty governing the extent and duration of sleep and have also noted that some patients begin to run unexplained fevers. The treatment in several patients had to be terminated for this reason. In some cases a marked tolerance to the barbiturate is developed, and I know of one patient, not in my own series, who received 300 grains of sodium amytal in one 24-hour period with no apparent deleterious effect.

Psychosurgery

Surgery in the therapy of mental illness was expounded by Cotton who attempted to surgically remove foci of infection in tonsils, teeth, stomach, intestines, cervix, tubes and ovaries.

Several operations were often performed on a single patient. This method rather rapidly was shown to be of little real value when subjected to controlled investigation by other workers.

Another type of surgery known as psychosurgery was originated by Moniz and promoted in America by Freeman and Watts. Attempt is made to sever the fibre tracts connecting the thalamus and the fore part of the frontal lobe. This is sometimes called prefrontal lobotomy.

Interference is thus made between the main brain stations having to do with emotions, and this acts to reduce troubling anxiety. In some patients anxiety seems followed by cheerfulness, lack of foresight, consciousness of self, and even mild elation. A definite restriction in emotional range seems produced. These workers believe that it is more useful in cases of agitation and depression, involutional melancholia, and some forms of schizophrenia and neurosis. Since actual organic damage is done to the brain by the treatment itself, it would seem more conservative to reserve this type of therapy for use after other less damaging therapies have been attempted and have failed.

INSULIN SHOCK AND SUBSHOCK INSULIN

Insulin shock therapy was first described by M. Sakel about 1930, at the University Clinic in Vienna. The technic was introduced in America about 1937, and for a time it gained unusual prominence in the psychiatric field. The method consisted in giving large doses of insulin to reduce the blood sugar to such a low level that coma resulted. The coma is terminated at the end of 1 to 3 hours by the administration of glucose. This basic technic is adjusted to the daily needs of the patient and thus forms a part of an eclectic type of therapy. The therapy was found to be particularly useful in cases of early schizophrenia, although it was tried in many other psychiatric conditions. It was found to shorten the course of illness in these patients and to give a somewhat larger percentage of recoveries. However, the treatment did not live up to its original promise, and because of the expense and nursing personnel necessary it was discontinued by some clinics and hospitals except in specially selected cases. There have been deaths reported from this treatment, and autopsy has disclosed some brain damage.

Subshock insulin treatment has also been used with a fair degree of success and is particularly indicated in the restless, excited mental states as a means of sedation as well as to increase the efficiency of the metabolic processes. Under such treatment the appetite usually increases quite markedly and the patient may gain weight very rapidly. The technic varies in different clinics, but the one most used consists in omitting breakfast, administering insulin in sufficient dosage to produce palpitation, tension and excess perspiration, which is then followed by a fairly normal sleep which never reaches the proportions of coma. After from 1 to 3 hours the sleep is terminated by the administration of glucose and other food. This treatment can be extended for an indefinite period as the condition of the patient indicates its necessity. Few complications and little danger have been described.

ELECTROSHOCK THERAPY

One of the most popular forms of physical therapy in psychiatric practice today is electroshock therapy. This treatment originated with Cerletti and Bini in Rome in 1938 and is now used in many psychiatric clinics and hospitals. By means of a specially constructed machine the patient is given a measured dose of electricity through the frontal area of the brain by means of 2 electrodes, one on each temple. This electrical stimulation produces a grand mal convulsion with the usual tonic and clonic movements, lasting about 1 minute, and this is followed by a confused period with drowsiness for from 30 to 60 minutes. Each patient is treated with the cervical spine overextended to prevent compression fractures of the vertebrae, and the extremities are controlled by trained attendants. With the usual machine there is no fixed voltage. The mechanism specifically regulates amperage and time of flow of the current. The amperage varies from 300 to 700 milliamperes and the time from 0.3 to 1 second. Treatments are usually given 3 times weekly but sometimes more frequently. The average number of treatments in some clinics is 12 to 20, while in other clinics as many as 75 treatments have been given to refractory cases. There are reports in the literature of patients who have received well over 100 treatments. Curare has been used to modify the convulsion in cases complicated by various organic defects such as hypertension, cardiac disease, disease of bones, and for a history of previous dislocations. Those patients suffering from acute depression seem to show the quickest and best response to treatment, although patients with acute catatonia and the exhilarated excitements also may show fairly good response at times. The psychoneuroses do not respond well for some unknown reason. In truth, the rationale of electroshock treatment is still unknown and is the subject of much speculation and theorization. Experimental variations in technic are being tried by various groups. Final judgment concerning efficacy must await detailed follow-up studies, but some workers now feel that electroshock does not help any patient who could not improve without the treatment. It primarily shortens length of hospitalization and illness, but even this is of inestimable value. It has supplanted metrazol therapy, due to easier control and absence of disturbing preconvulsive anxiety and aurae. Many critics of this therapy feel that it is dangerous because of the possible cortical brain damage. It is recognized that the electroencephalogram is abnormal for a period of several months after a series of electroshock treatments. However, in our series we found no positive evidence of any lasting organic changes.

Summation

A summation and discussion of modern methods of therapy in psychiatry, with particular reference to the physiogenic psychoses, psychogenic psychoses and the psychoneuroses have been presented. Due to lack of time the details of treatment technics could not be elaborated but those who are interested will find a wealth of such information in our present psychiatric literature. The art and science of the practice of medicine is not complete without knowledge of the function of human personality and it is the duty of every practicing physician to acquire as much of this knowledge as possible.

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RECENT TRENDS IN THE THERAPY OF LIVER DISEASE*

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As modern medical therapy develops we are learning more and more how significant a role the etiology of a disease plays in its proper treatment. In fact, modern concepts of treatment depend upon proper identification of etiologic agents before suitable and specific therapy can be given. Nowhere is this more evident than in the recent experience with the therapy of hepatic disease. Prior to the last decade, due to relative ignorance concerning the etiologic factors in hepatic disease, the therapy was merely symptomatic and at the same time usually hopeless. During the past years, concomitant with changing views of etiology resulting from experimental production as well as cure of liver disease, notably cirrhosis, our therapy has assumed a more logical rationale as well as a very decidedly more hopeful aspect.

The mainstay of modern treatment of hepatic disease is dietary and properly so, especially when the subject is viewed in the light of the role that the liver plays in digestion. The liver is virtually a huge metabolic factory intimately involved with all phases of metabolism, synthesis and detoxification of food substances. It controls by its secretion of bile the absorption and metabolism of fatty foods as well as the digestion of other food substances. By virtue of the circulatory relationships of the liver and the gastrointestinal tract, all products of digestion must first pass through the liver before they reach the remainder of the body. Because of this arrangement the liver practically controls the storage, manufacture and circulation of food materials. Dependent upon the bodily requirements, the liver is able to convert carbohydrates to glycogen or glycogen to glucose; to store and synthesize proteins, and deaminize amino-acids; to store minerals and vitamins and at least in the case of one, vitamin K, actually to convert it to prothrombin; and to detoxify harmful materials and end products of metabolism, as well as to perform numerous other metabolic functions as required. Not only are all these processes completed within the liver, but they are also regulated and correlated with other bodily functions and requirements.

Based upon these fundamental concepts of liver physiology, considerable experimental research has been done on the problem of protection of the liver by food substances and the treatment of hepatic insufficiency by diet. Not all workers are in complete agreement, but there is sufficient agreement to warrant certain general conclusions. In studies concerning the hepatotoxic effect of chloroform on puppies[1] it was noted that the higher the glycogen content of the liver the less the damage resulting from chloroform. It was further observed that a high carbohydrate diet[2] increased the glycogen content of the liver and made such a liver more resistant to the action of chloroform. Similarly, Bollman[3] has shown that carbohydrate affords the greatest degree of protection in experimental hepatitis produced by carbon tetrachloride. The work of Whipple and his associates[4, 5] has ably demonstrated the protective action of protein against hepatotoxic agents. It was also shown that the feeding of excess fat resulted in fibrotic changes in the liver, and Chaikoff and Connor[6] were able to produce cirrhosis in dogs fed a high fat diet. Gyorgy and Goldblatt[7] produced widespread hepatic necrosis in rats kept on a diet lacking the vitamin B complex. Rich and Hamilton[8] succeeded in producing true cirrhosis in rabbits fed a vitamin-deficient diet. The addition of thiamine, riboflavin, pyridoxine, nicotinic acid or vitamins A, D and E to the basal diet did not prevent the development of this cirrhosis, whereas a daily supplement of 5 grams of dry brewer's yeast afforded full protection. This was further corroborated by Von Glahn and Flinn,[9] who found definite evidence of protection against arsenical liver injury by the addition of brewer's yeast to the diet. Numerous observers have shown the presence of deficiency of the fat soluble vitamins A, D, E and K in hepatic disease, without, however, demonstrating any protective action by these vitamins.

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Impressed by the experimental data suggesting nutritional deficiency as an etiologic factor in hepatic disease Patek[10] in 1937 began treating patients with cirrhosis by a highly nutritious diet supplemented with vitamin B concentrates. Encouraged by favorable results in this first group of 13 patients he continued his work and in 1941[11] reported the results of treatment of a group of 54 cases of cirrhosis, comparing the results with those obtained from an evaluation of a group of 386 untreated cases. The diet used was rich in protein and ample in carbohydrate and fat. It contained approximately 3,600 calories in the following proportions: 139 grams protein, 175 grams of fat, and 365 grams carbohydrate. The diet consisted chiefly of meat, milk, eggs, fruit and green vegetables. Meat was served twice daily; milk 5 times daily, 3 times with meals and 2 times with 25 grams of powdered brewer's yeast. The yeast was given in graded doses, increasing up to the final amount. When brewer's yeast was not tolerated by the patient, oral vitamin B complex was substituted in the form of liquid yeast concentrates. In addition, thiamin chloride (5 mg.) was injected intramuscularly daily and liver extract, 5 c.c., twice weekly. When ascites was present, salt intake was restricted merely to the exclusion of the salt shaker from the tray, and fluids were allowed up to 2,000 c.c. daily. Too rigid restriction of salt and water was harmful and on occasion precipitated symptoms of hypochloremia. On this diet 60 per cent of the treated series experienced spontaneous disappearance of ascites, compared to 7 per cent of the controls. The period of survival of patients after the onset of ascites showed the following differences:

	Control	*Treated*
At 6 months	57%	72%
At 1 year	37%	57%
At 2 years	22%	45%

These figures are statistically valid and their significance is unquestioned. At the Mayo Clinic, Fleming and Snell[12] recently reported encouraging results in 50 cases of decompensated portal cirrhosis. Their diet was high in carbohydrate, rich in protein, and low in fat, and contained 3,000 calories, with 500 grams of carbohydrate, 110 grams of protein not derived from meat sources, and 60 grams of fat. In addition, the patients received daily 9 to 12 ounces of orange juice, 30 minims of oleum percomorphum, 6 to 12 brewer's yeast tablets, 4 to 10 mg. of thiamin and 2 fluid ounces of crude liver extract. On this régime 44 per cent of the patients were judged to have had excellent results, although only 22 per cent were free from ascites at the time of the report. In a recent report on the diagnosis and clinical course of 70 cases of fatty liver, Keefer and Fries[13] stress the therapeutic value of a high carbohydrate, low fat diet with a moderate amount of protein, supplemented with vitamin preparations and liver extract. They regard the fatty liver as a precursor of cirrhosis and suggest that intensive therapy at this stage, before fibrosis has occurred, can result in complete reversal of the process and recovery.

The above reports and the previously mentioned experimental data leave little doubt as to the importance of diet in the modern therapy of liver disease. It is generally agreed that this diet should be high in carbohydrate, about 400 grams, medium to high in protein, 110 to 140 grams, low but ample in fat, and contain 3,000 to 3,500 calories. The diet should further be supplemented by vitamins, particularly of the B complex, and fortified by liver extract. When definite vitamin deficiencies exist, as is quite common in liver disease, especially the chronic variety, they should be treated by adequate doses of the vitamin required, in addition to that which is given with the diet. In this connection the use of vitamin K should be mentioned for the cases of liver disease associated with tendency to hemorrhage, in which the use of this vitamin, a precursor of prothrombin, may help to alleviate the bleeding tendency by allowing the liver to produce prothrombin. Fluids and salt need not be restricted except in cases of ascites, and particularly in those requiring frequent paracentesis, because of the danger of producing hypochloremia. A neglected but very important feature of this dietary management is the question of good nursing care, since it involves feeding a patient to whom food is too frequently loathsome and undesirable. Infinite patience and encouragement are required to cope with the dietary likes and dislikes of these patients. It is of extreme importance for the nursing and dietetic service to be available when the diets are distributed. It is not what the diet tray contains but the amount of food actually consumed that counts.

Closely related to the newer concepts regarding nutritional deficiency as an etiologic agent in hepatic disease and the value of dietotherapy has been the recent interest in lipotropic factors. A lipotropic factor may be defined as a substance which prevents or removes an accumulation of excess fat in the liver. Included among these substances are choline, casein, methionine, betaine and inositol, and of these, the most popularly used and discussed is choline. The lipotropic activity of choline was first demonstrated in 1932 by Best, Hershey and Huntsman,[14, 15] who showed that the feeding of choline was able to prevent fatty livers in rats fed a high fat diet. Excess fat in the diet had long been considered an etiologic factor in the production of liver disease, and as pointed out above, Chaikoff and Connor[6] were actually able to produce cirrhosis in dogs fed a high fat diet. The relationship between nutritional deficiency and high fat intake was further clarified by Gyorgy and Goldblatt,[16, 17] who demonstrated the beneficial effects of choline on hepatic damage previously produced by high fat, low protein, choline deficient diets. Similar prevention of a fatty cirrhosis by choline was also reported by Blumberg and McCollum.[18] Lillie, Daft and Sebrell[19, 20] were able to produce cirrhosis on low protein, low fat, choline-deficient diets and prevent this cirrhosis by the addition of choline to the diet. Protective and beneficial action in rats was also obtained following the use of high dietary intake of casein[17, 19, 21] and methionine.[18, 20, 21] The latter, an amino acid, is a choline precursor and is present in large quantities in casein. Webster[22] has reported the successful use of betaine hydrochloride, a compound closely related chemically to choline, in the prevention of cirrhosis in rats. Inositol,[23] the newest of this group of lipotropic substances, has been shown to prevent fatty livers in the white rat. It is of interest to note that inositol also appears effective under conditions[24] unfavorable for the action of choline, particularly when large amounts of cholesterol are present in the liver.

The first clinical note on the use of choline in humans was reported by Broun and Muether,[25] who were quite favorably impressed. They used a low fat diet with choline chloride in a dose of 1 gram per day in 4 cases of cirrhosis and noted decrease in the size of the liver, elimination of the ascites, and an improvement in liver function as judged by liver function tests. More recently Rusakoff and Blumberg[26] reported their results with 10 cases of cirrhosis treated with a high protein, high carbohydrate, low fat diet, supplemented by vitamins and choline. They gave as much as 6 grams of choline per day in divided doses with no untoward effects. They feel that the use of choline resulted in definite improvement in their cases over and above that which could be expected from the pure dietary management alone. Aside from the experimental basis for the role of fat in the development of liver disease, pathologic study of autopsy material also suggests such a relationship. It has been shown that many diseased livers have increased quantities of fat[27] and particularly of neutral fat, the type of lipid upon which choline is very effective. The lipotropic action of choline is associated with the formation of phospholipids, and following the administration of choline there is a rapid turnover of fats and phospholipids in the liver. The other members of this lipotropic group, casein, methionine and betaine, have no such ability, but are able to supply methyl groups for the synthesis of choline in the intermediary protein metabolism, thereby accounting for their lipotropic activity. This factor should be considered whenever lipotropic substances are being used. The ultimate value of choline in the therapy of liver disorders must of necessity be decided by additional clinical use. As yet there have been too few cases treated upon which to base an opinion. The experimental data accumulated at this time would suggest, however, that lipotropic substances do rightfully belong to the therapeutic régime for hepatic disease. One would suspect that they would have their greatest usefulness in those cases in which the liver is undergoing some phase of fatty degeneration or infiltration, and before definite parenchymal destruction and fibrosis have taken place. Choline or any other lipotropic substance could hardly be expected to be of any value in the decompensated stages of liver disease in which the liver has already become scarred, nodular and fibrotic.

In addition to dietary management, which is the most important part of therapy, other therapeutic procedures are available, each of which may have application in suitable cases. The administration of parenteral protein either in the form of plasma or albumin should be considered in all cases in which the plasma protein is below the critical level. This will serve to tide the patient over the critical stages of the illness and until such a time as the damaged liver can recover and begin to produce the plasma proteins. The parenteral administration of protein, by changing the osmotic pressure relationships, may also help to diminish the edema and ascites and may on occasion result in diuresis. It may be administered as frequently and over as long a period of time as desired. Amino-acid preparations have also been used as a source of plasma proteins for patients with hepatic disease.

Most patients with liver disease have some degree of anemia resulting from blood loss, inadequate storage and intake of iron, or faulty production and storage of the erythrocyte-maturing factor, and, as a result, antianemic therapy is indicated. When the anemia is severe, repeated small transfusions are of great value, especially during the critical stages of the illness. When iron deficiency appears to be the etiologic factor, iron should be supplied in the usual fashion. Liver extract, particularly of the unrefined variety, is utilized as part of the general dietary régime and hence need not be supplied in extra amounts even though the anemia may be of the macrocytic variety. In addition to its antianemic effect liver extract appears to have general salutary and nutritive value and perhaps serves as a source of vitamin B complex. Recently a specially prepared liver extract for intravenous use has been developed, known under the trade name of Intraheptol. It has the advantage of being administered intravenously and therefore supplying larger quantities of this material to the circulation in a relatively short time. I have used this material* in about a dozen cases to date, and it seems to produce an increased sense of well-being in the patient over and above what other therapy will do. I have heard that this liver extract was recently used by the U. S. Army in the treatment of cases of hepatitis with seemingly beneficial and encouraging therapeutic results.

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* Supplied by the Lederle Laboratories, Inc.

Diuretic therapy should be considered in cases in which ascites or edema is present. In the mild cases limitation of fluid intake to 2,000 c.c. daily and restriction of salt are advisable. This can be followed by the use of saline diuretics such as ammonium chloride, given preferably in enteric-coated tablets up to 3 to 4 grams daily and supplemented by mercurial diuretics such as mercupurin given intravenously. The latter may be given every third day if desirable or if beneficial results are obtained. Careful and frequent urinalyses should be carried out when mercupurin is being used to detect early evidence of renal irritation. In the presence of well established ascites, diuretic therapy alone will rarely if ever result in the complete disappearance of the ascites. This will depend primarily upon the degree to which dietotherapy and other measures will result in the rehabilitation of the liver to a normally functioning organ. However, judicious use of diuretic therapy can very well prolong the intervals between paracenteses. Paracentesis has a definite place in the treatment of the ascites resulting from liver disease. It is indicated whenever the ascites has reached such a degree that it causes too great physical discomfort to the patient. It always introduces certain dangers inherent in the process, and because of this, as well as the fact that it is merely a temporary measure rather than curative, it should be delayed as long as possible. This does not mean, however, that paracentesis must await the time when the abdomen is literally bursting at the seams. Careful attention to the patient's weight curve and subjective state, coupled with frequent observation of the patient's abdomen and critical evaluation of the efficacy of diuretic therapy, should serve as the guides to paracentesis. Omentopexy or the Talma operation, in which the omentum is brought out into the abdominal wall with the hope of developing collateral venous circulation, has been largely abandoned as a relatively useless procedure.

Various surgical procedures have been attempted recently for the treatment of esophageal varices which occur in certain types of liver disease. Among these may be mentioned the ligation of the coronary vein of the stomach so as to take the load off the esophageal varices. Anastomosis of the splenic vein to the renal vein, to decrease the amount of blood in the portal circulation, has also been attempted. By far the most radical of these procedures suggested to relieve ascites and the strain upon esophageal varices has been splenectomy. Hypothetically, such a procedure should be very desirable, since it should greatly decrease the portal blood volume. Practically, however, due to the poor tolerance of patients with liver disease for anesthetics and surgical procedures, coupled with the shock of such a procedure, such an operation is an extremely hazardous one. Recently Barker[28] of Hopkins has reported a case in which this procedure was used with strikingly beneficial results. And finally must be mentioned the work of Moersch[29] of the Mayo Clinic, who has treated esophageal varices by the injection of sclerosing agents through an esophagoscope directly into the varices themselves. Final evaluation of these forms of therapy must await additional clinical trial.

The sulfonamides and the antibiotic group of drugs have little if any place in the treatment of primary hepatic disease. The former may have some questionable value in cases of Weil's disease, but then only when given early in the course of the disease. The presence of hepatic disease, however, does not preclude the use of these drugs, as recently shown by Finland,[30] and they may be safely used in patients with liver disease complicated by infections.

SUMMARY

Based upon the foregoing experimental and clinical experience with the therapy of hepatic disease, the following conclusions seem to be warranted.

1. A high caloric, nutritious diet, high in carbohydrate and protein, and low but ample in fat, supplemented by vitamins, especially of the B group, is the most promising form of therapy in degenerative disorders of the liver at this time.

2. Choline and other lipotropic factors, if used in suitably selected cases in which the liver is fatty in nature, should be of material value in hastening the response to dietotherapy.

3. The anemia and vitamin and protein deficiency of hepatic disease must be properly observed and treated if success is to be achieved.

4. Aside from paracentesis, the surgical procedures available at this time for the relief of the ascites of hepatic disease do not appear to be justified for the great majority of patients.

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RECENT ADVANCES IN ANESTHESIOLOGY

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THE last decade in the history of anesthesiology has been more important than all which went before in this specialty. It has set the stage for offering this service in improved form in all hospitals instead of by a very few skilled practitioners working in chosen places.

ORGANIZATION

The development of a pattern for good organization in an anesthesiology service is the most important of recent advances. Several factors have aided it. The whole movement toward specialty boards as outlined recently by White[1] has helped. The American Board of Anesthesiology, Inc. was an affiliate of the American Board of Surgery, Inc. from 1937 until it became a major board in 1941. The section on Anesthesiology of the American Medical Association was formed in 1940.[2]

These official bodies helped by such organizations as the American Society of Anesthesiologists, Inc., made such good progress that during the early days of the American participation in the war anesthesiology was given effective organizational status by the Army.[3] Today the functions of a complete service may be summarized as follows:

1. Administration of anesthesia for surgery and obstetrics.
2. Management of preoperative and postoperative routines as related to the anesthesia; especially anesthetic selection, preoperative depressant medication, and supervision of a recovery room where all unconscious patients may be watched.
3. Supervision of gas therapy with oxygen and other gases and of resuscitation on all services in the hospital.
4. Replacement therapy with blood and blood substitutes, at least during the period immediately related to surgery and parturition.
5. Administrative control of the operating room with special reference to sterilization and schedules.
6. Responsibility for diagnostic and therapeutic nerve blocks.
7. Responsibility for teaching residents in anesthesia, other members of the house staff and medical students; and for keeping the department functioning on a freely coöperative teaching basis for members and other practitioners.
8. Responsibility for conducting research, at least on a clinical basis.

Although it is realized that most hospitals cannot have a complete service, the use of this outline will enable any institution to set its sights on an attainable goal. Three factors are involved.

Equipment must be good and kept in perfect condition. Whether owned by the hospital or by visiting physicians this should be required because it is within the reach of all and at a very small cost per patient.

Financial arrangements must be good enough to attract competent physicians. The anesthesiologist must be on a prestige level with otherspecialists. The hospital must not exploit this service for shortsighted financial gain, because such a policy by injuring both physician and patient will ultimately harm the hospital too.

The critical factor in the widespread establishment of satisfactory anesthesia services is the severe limitation of specialist personnel. At this time there are more than 20 approved hospitals to each adequately trained anesthesiologist; there are more than 3 hospitals to each partly trained anesthetist. Because of this and because of the fact that anesthesiology, along with pathology and radiology, is essentially a hospital service, efficiency demands that the anesthesiologist engage in group practice or institutional service. He cannot spend a large part of his working day traveling between cases without harm to his patients and himself. These things all point to the fact that the qualified anesthesiologist should spend much of his time in supervisory work and in developing and maintaining organized collective effort to accomplish far more than any one individual could.

Thus it will bear repeating that advances in organization and the acceptance of their need constitute the greatest recent advance in anesthesiology.[4]

ANESTHETIC FUNDAMENTALS

Anesthesia is especially close in its relation to the basic sciences of medicine. There has recently been a widespread renewal of emphasis on these fundamentals. This is a hopeful sign and an important advance.

In the relation of respiratory physiology to anesthesia many articles are appearing on the role of oxygen.[5, 6, 7] The fact that many of these are not too logically presented indicates the widespread belief that a bandwagon is rolling in these fields and many want to climb on it.

The student anesthetist is now being taught that nothing is so important as keeping his patient adequately oxygenated at all times and that there are at least 7 ways in which he may fail to do this.[8, 9] Serious or even fatal anoxia may be:

1. Atmospheric. During gas induction the concentration of oxygen must not be less than 20 per cent at sea level. A very widespread induction technic illustrated by followers of McKesson[10] is now being discredited because of this principle.

2. Tidal. The tidal exchange of gases in the lungs must be adequate. The commonest error in anesthetic management is to allow obstruction in the upper air passages to lower tidal exchange. Many of us feel that the pharyngeal airway, credited to Connell, is the most important single piece of equipment in anesthesia. However, a more complete airway, and in many instances a more foolproof one, is the endotracheal tube developed by Magill[11] and others[12] after the first World War. Both of these important devices have had their use widely extended in recent years.

Hypoventilation with varying degrees of oxygen deficiency may be caused by foreign body or reflex obstruction to respiration as in vomiting. Central depression of respiratory control due to excessive depth of anesthesia may lead to the same bad result.

3. Alveolar. Primary or secondary lung damage may interfere with adequate amounts of oxygen passing the alveolar membrane.

4. Hemoglobic. Anemia or abnormal hemoglobin compounds may lower oxygen-carrying power of blood.

5. Stagnant. Shock with stagnation of circulation is the classical example of the way this factor may lead to anoxia. In severe form shock may progress almost as rapidly as apnea toward anoxic collapse.

6. Histotoxic. Inability of tissues to utilize oxygen may be quite variable. All general anesthetics may cause some grade of histotoxic anoxia.

7. Demand. The demand for excessive amounts of oxygen may be so great that it cannot be met by ordinary means. Anesthetic convulsions or severe hyperthyroidism are examples.

The extent to which an anesthetist can avoid complications will be measured directly by his ability to control these 7 dangers.[8] This is fundamental physiology.

Almost as important as the maintenance of oxygenation is the necessity for elimination of carbon dioxide. Only in the intact respiratory center is this drug an effective stimulant. Small excesses are definitely narcotic as reported by Seevers[13] and as indicated by the extensive experience of the Air Corps and of the Bureau of

Mines. Greater concentrations are definitely poisonous. One of the best indications that the profession is realizing the serious error in the eachings of Henderson and his followers was he Army order[14] last year eliminating carbon dioxide from use in their hospitals. This too is undamental physiology, and no anesthetist can gnore it.

Although it is more than 20 years since Waters[15] introduced carbon dioxide absorption nto clinical anesthesia, recent years have seen he use of this principle greatly extended.

The type of equipment used must be critically studied, because even new and expensive machines may embody bad principles. Two of the commonest dangers in use of a gas machine are accumulation of carbon dioxide and respiratory fatigue due to internal resistance in the machine. For example, if the soda lime cannister for circle rebreathing is too small, effective carbon dioxide absorption is impossible. Again, if the resistance to gas flow through the machine exceeds 2 mm. Hg pressure, the patient is endangered. Greater resistance, especially for children, may even cause pulmonary edema. A widely used machine has exhibited (on careful test of recent new models) resistance above 10 mm. Hg on both inspiration and expiration.

The ability to avoid such pitfalls is improved by the training in fundamentals now progressing among alert anesthesiologists.

RESUSCITATION

The body of knowledge on resuscitation has expanded greatly in the last decade. There is now fairly widespread agreement as to principles.[16] There is still an unfortunate amount of controversy over method. The over-all necessity is that oxygen be supplied to the tissues to reverse the changes of asphyxia. Immediate ventilation with air is better than with pure oxygen 3 minutes later.

Resuscitation of the newborn differs from that of adults in that time and place can be predicted. Proper equipment can and should be present. A clear airway is obtained by proper position and by aspiration of the throat. Oxygen is supplied to the lungs by intermittent, controlled, positive pressure inflations. Although manual methods of artificial respiration have a limited value in adults,[17, 18] they are not only useless but harmful in babies whose lungs have not been inflated.

The list of things not to do is almost as important as the positive obligations in resuscitation. Carbon dioxide should never be used because the asphyxiated baby always has too much.[14, 19] Such analeptics as metrazol, coramine, picrotoxin, and alpha-lobeline should be thrown out because they not only are ineffective during anoxia,[20] but, if the condition is improved by more physiologic methods (artificial respiration with oxygen), these drugs then materially increase brain oxygen requirement and may lead to convulsions.[21] Waiting to establish the need for resuscitation should never be tolerated. In the worst cases, a few seconds may be fatal. Difficulty is always increased. Physical stimulation belongs to the dark ages.

Studies of death under anesthesia show that most are caused by faulty resuscitation.[8] Close attendance upon the above principles, however, is improving the record amazingly in many institutions. The adequate dissemination of this knowledge is one of the important needs in the specialty. The widespread establishment of anesthesia study ocommissions was recommended by the AMA 2 years ago.[22] No more helpful step could be taken by any medical society than to follow this suggestion.

NEW DRUGS

All of the foregoing indicates the proper decrease in emphasis on specific drugs as the tools of anesthesia.[23] However, there is an agent which deserves special notice. The barbiturate, pentothal, presented clinically at the Mayo Clinic in 1934, has come to be used as the standard drug for intravenous anesthesia.[24]

For short light anesthesia and as an induction agent before inhalation anesthesia or for light sleep during spinal anesthesia it has come to have very wide acceptance. The presence of a gas machine or at least of resuscitative equipment in the room during intravenous anesthesia should be considered an essential safeguard. Furthermore, the temptation (because of its ease of administration) to use it too promiscuously should be curtailed where the airway of the patient is not adequately protected.

It is still too early to give a fair valuation to curare in anesthesia.[25] Certainly its use is now being abused by enthusiasts. It does seem to merit careful trial.

NEW TECHNICS

Continuous or fractional spinal anesthesia, introduced by Lemmon[26] in 1939, has proved to be valuable. This method, first with the malleable needle left in place but more recently with a fine ureteral catheter left in the spinal canal,[27] makes it possible to obtain relaxation with less danger, because repeated small doses may be given. The ideal of giving the drug only as it is needed instead of in one toxic dose is approached. The use of the catheter, with its tip near the cord segments to be affected, keeps total drug dosage at the lowest level consistent with controlled anesthesia.

Although the early publicity, both medical and lay, became objectionable notoriety for the continuous caudal method of Hingson and Edwards, this technic is now finding its place as one of the valuable forms of obstetrical analgesia.[28]

SUMMARY

1. Improvements in organization for anesthesia constitute the greatest recent advance in the specialty.

2. A renewed emphasis on anesthetic fundamentals is causing widespread improvement in clinical practice.

3. The knowledge of resuscitation is being clarified and disseminated. Anesthetic study commissions are being encouraged.

4. Pentothal is the most important new drug of recent years.

5. Continuous spinal anesthesia, using a ureteral catheter, is the most important recent technical advance.

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VIRUS PNEUMONIA: DIFFERENTIATION FROM PULMONARY TUBERCULOSIS

Report of Case

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It is common knowledge that atypical or virus* pneumonia may simulate pulmonary tuberculosis, clinically and roentgenographically. This is particularly so in upper lobe involvement, but the similarity may also exist in virus pneumonia with more extensive pulmonary infiltration.

The literature contains many extensive and excellent articles describing the clinical course and diagnosis of atypical or virus pneumonia. The gradual onset over a period of days, malaise, distressing, dry, hacking cough, postorbital headache, chilliness, remittent type of fever, noncharacteristic blood picture, absent or changing physical signs at times at variance with a fairly typical roentgenographic appearance, are well known. The mode of onset, character and bacteriologic content of the sputum, white blood cell count, X-ray findings, and response to the sulfonamides or penicillin help differentiate the disease from bacterial pneumonias. Unfortunately, no similarly clear group of diagnostic findings enable us to differentiate virus pneumonia from the occasional case of pulmonary tuberculosis with an acute onset in a previously healthy individual.

Serial roentgenograms are the most certain method of differentiation. Yoskalka[1] believes that the usual case of virus pneumonia shows complete clearance of pulmonary involvement in from 4 to 21 days. He also states that the persistence of cough and expectoration plus the finding of râles for a period greater than 21 days should lead one to suspect tuberculosis, even though the patient may appear to be improving. Since one not infrequently observes patients with atypical pneumonia who cough and expectorate for over a month, it would seem as if the persistence of râles would be the significant factor.

Upper lobe involvement presents the greatest difficulties in differential diagnosis, because this is the usual location of tuberculosis. According to Dingle et al[2] less than 15 per cent of atypical pneumonia patients present involvement of the hilar regions, the upper lobes or the middle lobe, and multiple lobe involvement is found in about 10 per cent of the cases. This type of lesion may simulate acute tuberculous pneumonia.

In the absence of tubercle bacilli in the sputum serial roentgenograms are therefore the most definite method for differentiation. Other laboratory examinations are not very helpful during the early critical days of an acute pulmonary disease when diagnosis is desirable. Negative sputum examinations do not exclude tuberculosis. The maximum titers for cold hemagglutinins and agglutinins for Streptococcus M.G. are reached between the 16th and 21st day following the onset of virus pneumonia.[3] These tests, although interesting and informative, are usually positive after differentiation has been made possible by roentgenograms and physical findings.

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* "The results of experiments conducted by the Commission on Acute Respiratory Diseases, Army Epidemiological Board, lead to the conclusion that primary atypical pneumonia is at least initiated if not caused in its entirety by a filter-passing agent, presumably a virus."—Present Status of Etiology of Primary Atypical Pneumonia. Bull. U. S. Army M. Dept., 1945, 5, 494.

The following case report illustrates the importance of serial roentgenograms in early differentiation between virus pneumonia and tuberculosis.

REPORT OF CASE

J. R. C., a 37-year-old white man, was apparently well until October 26, 1945, when he first noticed malaise, coryza, and a dry cough, all of which progressed in severity. He was first seen October 28, 1945, at home, complaining of a dry, hacking cough, sweats, sore throat, coryza and generalized aching.

In March of 1945 he had suffered from a detached retina which was operated on. The etiology was undetermined. He resumed his work of covering a laundry route. Three weeks prior to the onset of his present illness he had been in contact with a sister who had a virus pneumonia. The remainder of his history was not significant.

Examination revealed a tall, thin man in moderate distress with a temperature of 102°F., a pulse rate of 98, a respiratory rate of 20, a blood pressure of 118/70, nasal congestion, and pharyngeal injection with hypertrophied lymphoid follicles. Examination of the chest was negative. Treatment was symptomatic, codeine being given for the cough. The above symptoms continued with some abatement of the nasopharyngeal complaints and increase in the cough, headache and malaise. The cough continued to be dry, hacking and harassing. There was considerable retro-orbital pain with the headache. The temperature remained over 101°F., usually spiking to 102°F. or 103°F. every afternoon. On October 30, 1945, a white blood count was 6,000 with 60 per cent polymorphonuclear leukocytes and 40 per cent lymphocytes. On November 1, 1945 examination of the chest revealed slight impairment of the percussion note at the right base and an occasional sibilant râle in the same area. The patient was then transferred to Emergency Hospital.

By November 3 bronchial breathing with moist sibilant râles at both bases extending to the middle of the scapulae posteriorly and sibilant râles over the left chest anteriorly were heard. These signs continued with gradual clearing until November 10, 1945. The patient was quite ill. Malaise, headache, frequent drenching sweats, cough and evident weight loss were prominent. The sputum was scanty, increasing in amount as the pulmonary lesions resolved. The roentgenograms are reproduced in figures 1, 2 and 3.

On November 2 the white blood cell count was 10,150, with 77 per cent polymorphonuclear neutrophiles, 4 per cent band forms, and 19 per cent lymphocytes. On November 4 it was 6,600 with 77 per cent polymorphonuclear neutrophiles, 1 per cent band forms, and 22 per cent lymphocytes. The sputum was negative for tubercle bacilli on November 4, 5, 7 and 9. On November 7 many pus cells were found. Sputum culture on November 9 revealed Streptococcus hemolyticus. Urinalysis on November 2 showed a very faint trace of albumen and occasional hyaline and finely granular casts. These subsequently disappeared.

Dilaudid, $\frac{1}{32}$ grain (2 mg.) hypodermically, was required for relief of cough. Oxygen via a B.L.B. mask was utilized during the first few days. Penicillin, 525,000 units, was administered intramuscularly from November 2 to 5, without an apparent response. Sulfadiazine, 1 gram every 4 hours, was given from November 8 to 11. Aminophyllin, 7½ grains (0.5 Gm.), was given intravenously daily. It is now felt that the dosage of penicillin was too inadequate to definitely eliminate the drug as being effectual in the treatment. Sulfadiazine was administered while the temperature was receding, because of the sputum culture report of Streptococcus hemolyticus.

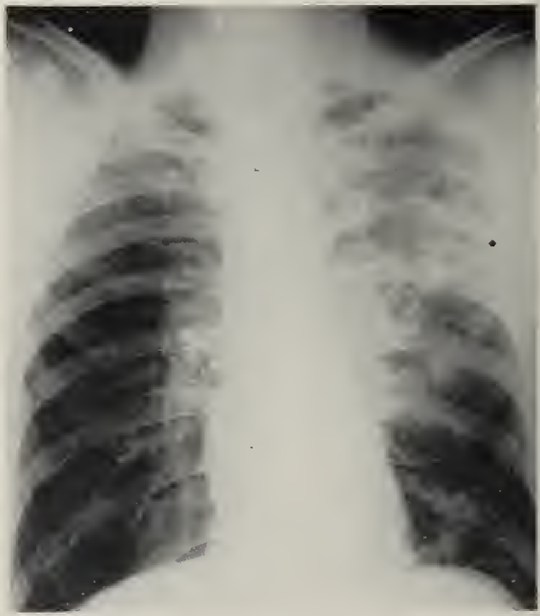

FIG. 1. Appearance on November 2, 1945

Convalescence was prolonged and was characterized by weakness and paroxysms of coughing, at times productive of purulent sputum. The chest remained clear. The patient resumed work, January 15, 1946, but continued to complain of an early morning paroxysm of coughing.

COMMENT

This patient had been exposed to a virus pneumonia several weeks prior to the onset of his illness. The illness began gradually over a period of several days with the symptoms of a "head cold" and pharyngitis until the more severe symptoms of the pneumonia supervened. The cough was most severe, dry and hacking; malaise was marked; the headache was severe. Physical findings in the chest were absent at first but progressed to generalized sibilant râles, thence to moist râles and bronchial breathing. The temperature was septic and remained elevated for 14 days. There were no tubercle bacilli in the sputum.

The original pulmonary roentgenogram on November 2, 1945 (fig. 1) revealed evidence of a marked patchy infiltration extending from the apex of the left lung to the level of the 5th rib anteriorly, resembling the findings of an acute tuberculous pneumonia. On November 11, 1945, definite improvement in the upper half of the left lung was noted, there being a decrease of the opacity (fig. 2). Spreading of the process to the base of the left lung and to the upper half of the right lung field was shown. The patient's clinical course and physical findings improved markedly from then on. Clearing of the opacity in the upper left lung field coincident with disappearance of the physical findings weighed heavily in favor of the diagnosis of virus pneumonia. A follow-up roentgenogram on December 12, 1945 (fig. 3) revealed complete resolution of the process.

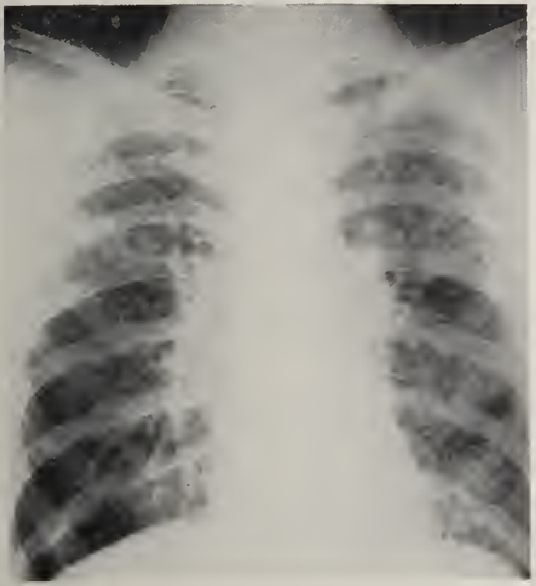

FIG. 2. Appearance on November 11, 1945

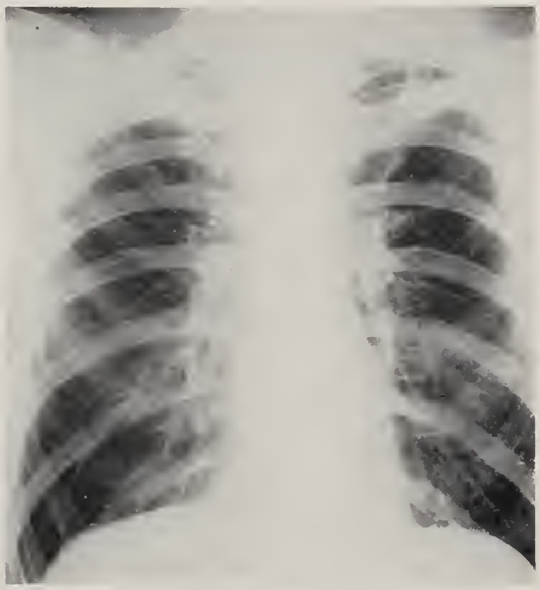

FIG. 3. Appearance on December 12, 1945

There are many variations in the clinical pictures of both virus pneumonia and pulmonary tuberculosis. This case report illustrates the difficulties encountered in differentiation. It is felt that the exposure to virus pneumonia 3 weeks prior to the onset of the patient's symptoms, the severe hacking cough, and the severe retro-orbital headache were symptoms which would lead one to suspect virus pneumonia despite the appearance on the first X-ray film, which was highly suggestive of tuberculosis. The clearing of the opacities, however, was the conclusive diagnostic criterion.

(*Continued on page 411*)

President's Page

CONVENTION IMPRESSIONS

The California meeting of the American Medical Association was marked by enthusiastic interest in socioeconomic as well as scientific aspects of medicine. As a matter of fact, the entire atmosphere of the meeting was charged with this spirit.

Activity in the House of Delegates gave evidence of the delegates' appreciation of the value of good public relations. The House enacted far-reaching resolutions which will result in more dynamic, active and, I am sure, fruitful efforts to inform the public as to what physicians are doing, what good medicine is, and the valuable contributions of a scientific nature in the field of medical research.

In spite of the unusual interest in the activities of the House with respect to public relations and medical socioeconomics, the scientific program deserved and received wide attention. The quality of the scientific program and exhibits proved to be a continuation of the high standards which the annual meetings of the AMA have maintained over the years.

You will be interested to know that at the Conference of Presidents and Officers of State Medical Societies, emphasis was placed on the establishment and enlargement of prepaid medical plans. This group evidenced great interest, too, in the nature of public relations programs of the various state medical societies. Progress made by the California State Medical Association was particularly exemplary and inspiring. This organization has seen to it that funds have been provided to do an adequate job. They have also seen to it that each member of the Association is made conscious of the responsibilities which membership imposes upon him. The manner in which these objectives have been achieved is most interesting and merits the study by the medical profession throughout the country.

It was very helpful to me to hear about and see what is being done elsewhere. Some of what I learned will, I am sure, be most helpful in the task of assisting in the direction of our activities in the District of Columbia.

As I came away from the meeting I could not help but be impressed with the fact that leaders of the medical profession in this country are keenly aware of the effort being made by certain political groups not only to regulate but to control the lives of the people of this country. Medical leaders at San Francisco indicated their intention to do everything in their power to prevent such regimentation in the belief that human beings should be allowed to retain their dignity and individuality.

William P Herbst Jr

Editorials

CONTRIBUTIONS OF THE PROFESSIONS TO INTERNATIONAL UNDERSTANDING AND PEACE*

The professions are extremely fortunate because they can contribute to international understanding and friendship in a war-torn world. This is possible through the exchange of our literature and by visits to foreign countries to acquire new knowledge and ideas from our distant colleagues. The writer, for example, has many personal friends in every country of the world. He considers himself wealthy because of these friendships, and knows that they will grow stronger and richer, like good brandy, as the years roll by.

Because we are Americans, we have a New World attitude and outlook which frees us from the Old World traditions, customs and thoughts. In the past, because of distance, it has been difficult for us to know each other as well as many of us would have liked. With air travel the future presents a different picture and, perhaps, for us a better one. The day of competitive nationalism and nationalistic thought has passed into the larger and greater realm of international thought and coöperation. The United Nations is a symbol of this trend.

The United States is rich in minerals and all of the basic necessities of life. Some countries have more of these basic materials than others. Therefore, it is necessary to develop an exchange and obtain a fair distribution of these things so that we may all live in happiness and peace. To accomplish this exchange requires understanding and knowledge of one another. This is where the professions of each country can play a very significant role.

First, we all have a common language of scientific, anatomic, and legal terms. This language should be extended and coördinated so that more words are identical in all languages.

Second, we have the same daily problems in our practice, regardless of whether we practice in New York, Mexico City, London, Buenos Aires, Paris or Moscow. Most of our patients come to us in pain or in fear, and usually with insufficient money to pay for the work to be accomplished.

The materials that we use must be of the finest and yet each of us has had the experience of being supplied with inferior materials which have made our work difficult. All this because there was not any foreign commerce between certain nations because of war, tariffs, or misunderstanding.

Because of the unfavorable money exchange it has not been possible for professional men of other countries to visit frequently in the United States. Nor has it been possible for them to buy current American textbooks. On the other hand, the average American usually takes a two or three weeks' annual holiday and this short time does not enable him to visit adequately a foreign country.

But this is now being changed. Americans are becoming aware of the great cultures and civilizations which exist in all parts of the world. There is a keen desire on the part of the American professional man to know more about the work of his colleagues in all parts of the globe. As this interest grows, more of our best scientists will travel and spend a sufficient time watching the work of leaders in other countries. Until foreign travel is easier, much good can be done by personal correspondence, and it is suggested that you endeavor to communicate with those friends and colleagues in other countries whose work you admire.

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* This is the sixth in a series of guest editorials by distinguished scientists and laymen. Others to follow will deal with the scientific, social and economic aspects of medicine.

The medical, dental and legal professions of any country are only a small segment of its population, but because of their daily contacts, they can exercise a tremendous force toward understanding. Because of this, they become an important force in developing international understanding and contributing toward world peace. We must become better acquainted with one another. We must exchange ideas and technics. We must have sympathy and appreciation for each other's work and problems, and we must make an individual effort to express all this. This is not a one-man job. It is the responsibility of every individual professional man. Toward this end, international conferences and meetings should be encouraged and arranged.

In the postwar world, the professions in the United States, like medicine, dentistry, law, etc., have an opportunity and an obligation to contribute to the rehabilitation of these professions in the other nations of the world. It is a task that should be done immediately and it is one that will bring everlasting reward and gratification in the development of new friendships and the exchange of valuable knowledge.

The liberated countries have much need for assistance in the reorganization of their professional societies, schools and libraries. Many of the countries have been without foreign contacts since 1939. During this time, they have developed new technics in all fields of practice based upon a limited supply of materials and, in many instances, on ingenuous substitutes. We should know what they have learned and they want to know what has been the progress in research in the free world in which we have the privilege to live.

Understanding is an armament in the defense of our country just as much as are tanks, battleships or airplanes, and the cost of achieving it is a good deal less than the cost of building and maintaining tanks, battleships and airplanes. The sooner the peoples of the world come to realize this fact, the sooner they will force their governments to give equal importance to the international exchange of scientific and cultural information. We must know more about each other if we are to understand and respect each other's problems. It is difficult to dislike someone whom you respect.

As it is with persons, so it is with nations. Understanding is the first factor in world peace. It is the one thing toward which all persons can contribute. The professional man by the very nature of his work, however, is in a unique position for the reasons stated above. For him to ignore the opportunities of the present period in world affairs would be a mistake. He will find that enjoyment of his work will grow with the widening of his horizon.

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American Dental Association

THE HOSPITAL LIBRARY

The recent critical survey made of the hospitals of the District of Columbia omitted any reference to the medical libraries of these institutions. Upon inquiry, it has been ascertained that approximately only one third of the general hospitals, not connected with medical schools or the Government, have medical libraries that are adequate for the staff and visiting physicians, and meet the minimum standards for residents and interns as well as the educational requirements for post graduates.

In this present era, when advances in medical science are never static, the physician's personal library is inadequate to keep him well informed, and with the increase in demand upon his time, it is essential that every general hospital have at least a small medical library. The wealth of material in two of the world's largest medical libraries, the Army Medical Library and the Library of Congress, should only be additional resources to the individual hospital medical library. The compass of such a collection should conform to the size of the hospital, to be supplemented by the other library facilities. Minimum standards for hospital medical libraries have been set by the Council on Medical Education of the American Medical Association[1] and by the American College of Surgeons.[2]

The medical library is not a development of our modern age. In the classical period of Greece, Aristotle was the first to have a library that could be so designated. There were many books in his collection on biology and medicine. During the Roman Empire the acquisition of a library was considered an achievement, and in the Graeco-Roman Period, the contributions of Galen, Pliny the Elder and others were preserved in the temple libraries.

As civilization progressed, more medical libraries were established. As early as 1369 a medical school in Paris had started a collection of books. The Bibliotheque Nationale of France, now holding an extensive collection, was started in 1518, and in the same year the library of the College of Physicians in London was founded. In America, the first medical library was begun in the Pennsylvania Hospital in 1762. In 1788 the Library of the College of Physicians was organized.[3] The Surgeon General's Library, founded in 1836, has become the world's largest and best medical library.

With the advance of medical education and the elevation in standards for hospitals, the medical library acquired educational importance predicated on the publication of additional medical books and journals to an unprecedented degree. There are many excellent medical libraries in the United States, but those in the hospitals of the District of Columbia do not show up too well by comparison. The average medical library in many institutions, here and elsewhere, consists of a small collection of books, many obtained as gifts. Out-of-date volumes predominate in number. The books are not carefully selected for the needs of the staff, and there is little, if any, classification and cataloguing. The number of current medical journals is usually limited, with few or no bound volumes, and if bound, are often obsolete. Rarely is the collection properly housed and located, or supervised by a trained librarian. A varied personnel is revealed; a laboratory technician, an intern or resident, a medical secretary, the record librarian, or perhaps only an honor system is employed to administer the library. There are few professional librarians. High standards in the medical library depend on the organization and service; the qualifications of the librarian greatly improve its intellectual level.

Is it too much to ask the hospitals of the city of Washington to consider the organization and maintenance of a modern medical library with a professional librarian in charge? Is it not consistent to have the library on the same basis as other necessary departments of the hospital that are staffed with professional personnel and properly equipped?

This should be the aim of every well-equipped hospital, and is a problem worthy of serious consideration. The influence of a fine, though small, library can penetrate all departments, and be a strong educational factor with a collection that is pertinent, practical and progressive. There is limitless opportunity for the physician to broaden his medical education. Osler truly stated, "To study the phenomena of disease without books is to sail on an unchartered sea." The spirit and purposes of the medical library do not change; only the scope changes and the aims expand.

C. S. W.

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[1] J. A. M. A., 1945, **128**, 228.

[2] Bull. Am. Coll. Surgeons, April 1941; corrected to September 1, 1943.

[3] Doe, Janet: Handbook of Medical Library Practice. Chicago: Am. Libr. Assoc., 1943, pp. 1-10.

THE FUTURE OF MENTAL HOSPITALS

A century ago Dorothea Lynde Dix called public attention to the neglect and abuse of the mentally ill. This she did so forcefully that over 30 mental hospitals were established (or enlarged) in this country, among them St. Elizabeths Hospital, an institution which she intended should care for the then neglected mentally ill of the Army and Navy.

These and the other public mental hospitals were, however, with but few exceptions, administered as a part of the "charitable" organization of the states, the emphasis tending to be on custody and low cost. A few states, recognizing the medical nature of the problem, provided medical leadership and reasonably adequate appropriations, but these were exceptional. Too often building programs lagged and money was not forthcoming for personnel suitable either in numbers or quality; sometimes, too, political influences controlled appointments. Patients accumulated, custodial care tended to supersede treatment, and brutality at the hands of inferior and untrained attendants was not unknown. Although many conscientious physicians, nurses and attendants did their best under discouraging conditions, their efforts were unsung, and the protests of those who desired improvement often failed to overcome budgetary "economy," legislative inertia, and public apathy.

The conditions recently given wide publicity represent an accumulation of years, accentuated by the moratorium on building and by the manpower shortages caused by war. Making all possible allowances for exaggerations and undue generalizations, there is no doubt that much needs correction and that the public is interested in bringing about such correction.

The opportunities for improvement cannot be met except under certain conditions: (1) adequate funds for the relief of overcrowding, for the provision of treatment facilities, and even more important for the securing of well trained psychiatrists, nurses and attendants who approach the problem professionally; (2) security of staff members, meaning particularly freedom from political interference; (3) opportunities for further training, for research, for contact with active medical centers; (4) an enlightened public interest, which recognizes mental disorder as a medical problem as "respectable" as any other, as something treatable and in its early stages usually curable, an interest which will insure that no undue obstacles are thrown in the path of the returned patient; (5) the establishment of more facilities in the form of outpatient clinics, psychiatric wards in general hospitals, and free and simple admission to mental hospitals.

The Federal Government, by its passage of the National Mental Health bill, has given official recognition to the need of research and training in the field of psychiatry. The American Psychiatric Association, the oldest national medical organization in the country, has recently set up a Psychiatric Foundation as a private agency to disseminate knowledge and to promote research and study. Through such a means the current public interest may be mobilized in a tangible way. From almost every point of view, numerically, economically, socially, the half million mentally ill in our hospitals and the countless others who are suffering from emotional handicaps constitute a greater and more pressing problem than the other better popularized groups of the disabled for whose benefit large sums are raised annually.

In this field as in others the state or any other agency cannot undertake medical assistance without public interest and coöperation.

W. O.

In and Out of Focus

BY THE OBSERVER

Lack of Candor About Controls

Although it is quite certain that the Wagner-Murray-Dingell bill will be shelved by Congress and not much can be gained by further discussion of this legislation, other bills of a similar nature will undoubtedly be introduced in the not too distant future. There is ample justification, therefore, for publishing material which throws a new light on the now historic S.1606.

Writing on the subject "Compulsory Prepaid Medical Care," Mr. W. A. Milliman, Second Vice President of the Equitable Life Assurance Society, places the proposed legislation under the microscope with some interesting results. Charging proponents of the bill with not having been frank in regard to controls which would be necessary to the successful operation of a compulsory health insurance system, Mr. Milliman says:

> "In the first place it is certain that many controls would be necessary both as to the manner in which the medical practitioners could practice their professions and as to the conditions under which eligible persons could avail themselves of medical services. These controls would probably be of such far-reaching character that they would result in unforeseen changes in the present bases of the practice of medicine. There has not been sufficient discussion of the necessity, under a plan of compulsory health insurance, for such controls, nor has adequate consideration been given to their probable consequences. While the proponents of compulsory health insurance have apparently given some consideration to these problems, they have not been frank with regard to these points with either the medical profession or the public."

He dwells at length upon the responsibilities of the Surgeon General of the United States Public Health Service for the administration of compulsory health insurance features of S.1606.

> "It is . . . certain that a national health program such as proposed would cost a great deal of money. It is suggested that this cost would not be materially greater than the price now being paid by the American people for health care. Whether or not this is true the Surgeon General would have to keep the cost of the program within the limitations imposed by the revenues available. If abuses developed, abuses which cost money and threatened the solvency of the program, the Surgeon General would be forced to take steps to cure those abuses, or to limit their financial effect. Whether he seeks to cure the abuses by regulations limiting the conditions under which an individual can obtain medical service or regulations restricting or prohibiting certain medical practices, or whether he seeks to limit the financial effect of abuses by changing the basis of compensation of physicians and dentists, these regulations can, and probably would, fundamentally alter many features of the present system of medicine and medical economics.
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> "The avowed purpose of the bill is to give everyone ready access to good medical care. The Surgeon General must, therefore, obtain the participation and the coöperation of the medical professions. Without that participation and coöperation, including that of the more competent members of these professions, the plan would be an empty gesture. Whatever the justification for their attitude, the violent reaction of the organizations representing the major portion of the medical professions would indicate that such coöperation cannot be achieved at this time. Nor does it seem likely that their coöperation can be obtained in the future if there is a continuation of the lack of candor which has so far characterized the proponents of this type of legislation. The sort of coöperation which is necessary cannot be obtained by compulsion. If there is a reasonable basis for coöperation, obviously it can be best attained by a full and frank exploration of the necessary readjustments in the present system of medical care with such exploration made jointly by the advocates of such legislation and representatives of the moderate and conservative elements of the medical professions."

More hospitals would be necessary, Mr. Milliman points out, if this legislation becomes effective. He observes that President Truman has recommended financial assistance to the various states for the construction of more hospitals and that legislation for this purpose is being favorably considered by Congress. But building additional facilities is not enough. There must be trained personnel. And the question arises, he says, whether the professions will lose their attractiveness for the young people of our country if a program such as is proposed becomes a reality. Along this line, Mr. Milliman comments:

"Because it affects the attitude of the present members of these professions and the attitude of the potential future members, a most vital part of the program is the basis upon which those who render the service required under it will be compensated. The bill provides that the basis of compensation for general practitioners and dentists shall be determined by the majority of such practitioners in each local area with the right reserved to the Surgeon General to use a different basis of compensation for those who do not elect with the majority. It is well known that the majority of physicians in private practice today wish to continue the traditional fee-for-service basis of compensation for their services. It is with respect to this point particularly that the proponents of compulsory health insurance have lacked candor in dealing with the medical profession. While the bill provides that the doctors of any area may elect to continue to be paid on a fee-for-service basis, the principal proponents of this type of legislation, in a statement entitled 'Principles of a Nation-wide Health Program' published in November 1944, stated that:

" 'The fee-for-service method is most open to abuse by patients and physicians and is the most costly to administer. Adequate control of the services requires fiscal and professional supervision, which is expensive and often vexatious. The promotion of quality and of prevention is difficult. The use of the fee-for-service method should therefore be discouraged, except for specialist services under certain conditions.'

"What would be the result, then, if the Surgeon General must permit the doctors of each local area to choose a method of compensation which experts in the field agree will not work, and it appears that a majority of doctors will choose that method? One of the first steps might be to reduce the rate of payment for each unit of service so as to bring the over-all cost of services within the available funds. To reduce the pay of conscientious and competent physicians because of abuses by patients and by less conscientious physicians would be intolerable. The conscientious doctor, if he is to receive the compensation to which he is entitled, would be forced to make unnecessary visits and adopt many other undesirable practices followed by the physician who has abused the system. There would result an application of Gresham's law to the field of medical practices, with the bad driving out the good.

"The next step might well be the abandonment of the fee-for-service method as a basis of payment to the general practitioner. The alternative bases of compensation contemplated by the bill are payment to the general practitioner of a stipulated amount each year for each of his patients, the so-called capitation basis, or payment for the physician's services on a salary basis. These are, by and large, methods untried in this country in the field of general medical care. What effect they would have on the quality of medical care, its cost, and the attractiveness of the field of medicine to the present and the potential future doctors, dentists and nurses is practically unknown.

"It might be observed, however, that the capitation method, under which the physician is paid the same amount each year regardless of the work he performs, opens at least two avenues for substantial abuse. In the first place it would be to the financial advantage of the individual physician to avoid taking patients who are apt to require a substantial amount of medical care. There are many ways in which the physician could select his patients for this purpose, and apparently he would be free to do so since the bill would permit the physician to reject individual patients. In the second place the general practitioner would find himself able to handle more patients, and hence to increase his income, if he made a habit of referring patients to specialists as soon as some minor complication arose. Other serious abuses are possible. Whether these abuses would become realities, or would prove to be purely imaginary, can more properly be determined by experimentation with voluntary plans rather than by adoption of a nation-wide compulsory plan.

"What would be the result if a salary basis of compensating physicians were substituted for our present fee-for-service basis? Would professional standards be higher or lower than at present? Would the net change in the picture, including the introduction of political and bureaucratic forces, make the medical professions more or less attractive to qualified potential entrants into these professions? The recent disclosures concerning the medical care provided through the Veterans Administration is disquieting in this connection. Certainly a careful examination of the character and quality of the services which are now being supplied by physicians employed on a salaried basis, including an investigation of the reasons for any shortcomings in the quality of that service, should be made before seriously considering adopting a national system which may force this as a general basis of compensation of physicians."

Another method, Mr. Milliman says, might be tried to limit the financial effect of abuses by restricting the conditions under which the individual could obtain the services of a physician, dentist, or hospital, or, he says, by "prohibiting certain types of practices by physicians, dentists and hospitals."

"Let us take a simple case by way of illustration. The Surgeon General might find that some physicians being reimbursed on a fee-for-service basis were making four, five or six visits for treatment of common colds where one visit would have been sufficient. In order to reduce the financial burden of this type of abuse he might decide that in any case diagnosed as a common cold the physician would not be allowed payment for more than two visits without specific approval of the case by a medical administrative officer. Obviously, it would be a simple matter to circumvent such a restriction by changing the diagnosis. Consequently, if the necessity for such restrictions and regulations should arise in practice, the variety of diseases and the diversity of medical practices would inevitably lead to a formidable volume of rules, regulations and report forms. Serious consideration should be given to the effect of such procedural problems on the ability of the physician to practice medicine efficiently and effectively.

"The controls over the individual physician paid on a fee-for-service basis would arise from the necessity of the Surgeon General to limit costs. Use of a capitation basis or a salary basis has been suggested in order to avoid the problems of the fee-for-service basis. While these bases of compensation would be effective in limiting costs it is not clear that they would be effective in maintaining quality of medical care. Consequently, the controls which would be required under a salary basis or a capitation basis would probably be concerned with the problem of trying to assure a high quality of care, and would probably do so by detailed regulations as to the precise manner in which the physician should practice medicine. Such a development would be accompanied by the grave danger that, by placing an administrative stamp of approval on currently accepted methods of treatment, new technics and methods of treatment would be difficult to adopt, and might, in fact, be strangled by administrative red tape.

"In addition to attempting to control abuses by adopting new methods of compensation, or by regulating the methods of practice by physicians, dentists and hospitals, the Surgeon General might have to limit the services which would be available under the proposed system. Such limitations are specifically contemplated by the Wagner-Murray-Dingell bill. For instance it is obviously impossible for available personnel to furnish complete dental services to the entire population. Accordingly, the Surgeon General would be permitted to restrict the dental services to examination, diagnosis, prophylaxis, extraction and treatment of acute diseases of the teeth. Home nursing service and laboratory benefits might likewise be limited, because of restricted personnel and in order to control costs. In addition the Surgeon General would be authorized to require the payment of a fee with respect to the first service from a physician, dentist or nurse, or with respect to each service in a period of sickness or course of treatment.

"One of the main objectives of those who propose compulsory health insurance is to obtain greater emphasis on preventive medical care. The Wagner-Murray-Dingell bill recognizes, however, that sheer lack of available personnel, coupled with possible lack of funds, will limit that emphasis, and that abuses may arise which will necessitate barriers to such care."

Mr. Milliman believes there is need for improving preventive medical care, the establishment of diagnostic centers, and the development and experimentation with voluntary plans for prepayment of the costs of medical and hospital care. He pleads for "a more constructive attitude by the medical profession, by the insurance industry, and by employers."

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Doctors Must Act Physicians are particularly sensitive at present to what members of Congress say about them. They are especially attentive when a Senator or a Congressman expresses himself on any phase of medical care. For they are only too well aware that it may have considerable significance.

In mid-April of this year, Senator B. B. Hickenlooper of Iowa addressed the 59th Annual Session of the Iowa State Medical Society. He spoke at length on controversial medical issues, leaving no doubt in the minds of his listeners that he stands firmly on the side of organized medicine. But he also made it clear, as other conservative Senators have done, that prompt action by the medical profession is called for.

For the threat of paternalism is inherent in the confusion which now exists.

> "As may be expected, the War and this period of postwar conversion pose countless problems," Senator Hickenlooper said. "These problems are social as well as economic and are often confused in the restlessness resulting from the tremendous desire on the part of everyone to be relieved of the tension of war and to get back to the calmer pursuits of peace. It is during such a period that emotions run high, that ideas flow from fertile brains in great volume, offering plausible solutions for difficulties which manifestly need attention; but, by the same token, it is during such periods of confusion that seemingly plausible solutions may be adopted without proper analysis or without calm consideration of their ultimate results. In such circumstances we are often led to accept the tinsel for the gold and to find, when the glittering stage settings are taken away, there remains nothing of the illusion they created.
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> "We have a great tendency, when we talk about matters involving social security, to confuse or to unite security with freedom and to consider them as synonymous. They, of course, are not synonymous, and when security is had as a result of government paternalism, it results in a corresponding reduction of the fundamental freedom of the individual."

As was to be expected, he disapproved the Wagner-Murray-Dingell bill. "In my opinion," he observed, "it would be the most far-reaching regimentation law that we have yet experienced and would amount to a practical socialization of not only the economic lives of a great percentage of our people, but it would, through its establishment of Federal medicine, set up controls over the health and lives of our people to a degree that is unthinkable."

However, Senator Hickenlooper qualified his opposition to this legislation in these words:

> "The very fact that tremendous demands are being made to meet deficiencies in our public health programs and to bring better medical and health programs to underprivileged people indicates there is a need and a field in which we should not only give every consideration, but should act with judgment and with speed. While I am opposed to the over-all socialization of our health programs, and I am especially opposed to the socialization of medicine because I believe such philosophies destroy initiative and encourage indolence and thereby become detrimental in the long run to the public, nevertheless the problem must be solved.
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> "I think it is being rapidly solved in the American way although not so rapidly as the planners desire, but I believe it is being solved through the development and establishment of private associations and private groups through health and hospital insurance and, I hope, medical insurance . . . I assure you that I believe these programs, looking to the discharge of responsibility for the health needs of the individual, must be met and methods devised so that the individual can carry his equitable share of that responsibility and not look to a paternalistic government or a paternalistic group to give it to him for nothing.
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> "These programs must, of course, provide insurance or fee services at a price within the economic reach of each class of individual, and they are so provided in many places. Such programs, however, must come from practical and trained people in the professions and the services themselves, people who know the problems intimately and who are best qualified to give the answer. I know criticism has been made that the medical profession has not moved with any alacrity along this line, but I think that is not true. I think there is ample evidence in communities and localities all over this country that the medical men of the Nation do realize this problem and are working out plans of self-help for their communities and for their states, whereby individuals can secure the best of services at a price that can be paid. It has always been my opinion that it is better for a person of low income to have an arrangement whereby he can pay a modest fee, proportionate to his income or ability, and pay the debt or the obligation himself, retaining his own pride in meeting his debts and taking care of himself and his family, than it is toprovide such services by way of governmental donation or public or private charity."

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What Antivivisectionists Want

"Antivivisectionists" are thoroughly taken apart by Bernard DeVoto in the June number of *Harper's Magazine.* He leaves very little unsaid about these crusaders whom he accuses of forcing "doctors and medical researchers of the state to drop their proper business and take to the platform and fight. (And to fight in the acid knowledge that they are making additional publicity for the society and therefore more contributions to its endowment.)" For the professionals who direct campaigns for "antivivisectionists" Mr. DeVoto reserves his sharpest barbs.

"Such a campaign is always planned and directed by professionals," he says. "They are experts; they are trained fiscal and financial managers, fund-raisers, personnel directors, press agents, agitators; they work impersonally, by proved means and tested instruments. Their campaign enlists the sympathies of unpaid volunteers—elderly sentimentalists, yearning and desirous people whose hearts are full of pity for our dumb friends, escapees, the perpetually censorious, the perpetually indignant, the perpetually confused. The pro's organize the volunteers as for a Red Cross drive. The press, the pulpit, the radio are besieged. Literature is spread broadcast. Set pieces are arranged, perhaps the arrest of a university president or a raid on a medical school. A vigorous and almost convincing effect of widespread public interest is contrived.

"To what end? To the maintenance of the salaried jobs and the replenishment of the treasury. The volunteers may want that bill passed; and the society may think *it* does. But it does not. It wants publicity and cash. The legislature's greatest service will be to defeat the bill, so that the society may introduce it again at the next session, stage another campaign, and raise more money."

Mr. DeVoto admits that the attitude of the professionals is understandable. He can also understand the "earnest volunteers" who are upset by the descriptions of "fiendish men inflicting atrocious pain on helpless, but always loving, animals."

"But the front men and women," Mr. DeVoto writes, "are harder to understand. These are the people of local prominence who fill the unpaid, honorary offices of the society, who sign the literature and manifestoes which the professionals write, and who appear on public occasions which the pro's arrange; who use their position in the community and a perhaps genuine distinction earned in other fields to guarantee the society.

"Their zeal is a danger to all of us, but their irresponsibility is a greater danger. They exhibit ambiguities and it is not fair to dismiss them as necessarily either fools or liars—though it is difficult to believe that they are always unaware that the statements they issue and the literature they sign are mendacious, composed almost entirely of misrepresentations, distortions, and misstatements. On the other hand, it is not fair to excuse them as merely sentimental yearners, deceived or self-deceived, for they usually turn out to be quite indifferent when the misstatements are exposed as such, and they escape into a sanctimonious self-righteousness that cannot always be unconscious. The most cleanly of them may be thought of as perturbed spirits for whom sentimentality affords a refuge from thought and who find 'antivivisection' activity a protection against reality, since it gives them a comforting sense of combating evil while it anesthetizes them to the genuine evils which a sensitive conscience might otherwise require them to face and acknowledge.

"But the driving force of certain others—the more certainly as that drive is the more energetic—needs psychiatric explanation. An appearance of benevolence, kindness, pity, and the championship of the helpless is a gloss that covers a pathological misanthropy, a residue of primitive totemism, and a still more primitive destructiveness. In the extreme 'antivivisectionist' may be observed one manifestation of what Freudians call the death wish. The pathological champion of animals is pathologically afraid of mankind—or a pathological hater of men."

Directing his attention to the propaganda of "antivivisectionists," Mr. DeVoto has this to say:

"An examination of the literature circulated by 'antivisection' organizations in both states,* and of the supporting propaganda in the Hearst press, makes an absorbing if repulsive study in the manipulation of sentiment. That this literature is in great part dishonest goes without saying: much of it could not be written honestly at all. That many of the statements made in it are made in flat and open contradiction of the facts, that they are deliberate lies, also goes without saying: the case against the medical schools and scientific foundations could not be made without lies. Yet the lies are less important than the innuendoes, the conscienceless use of irrelevant sentiment to support mendacity, and above all the irresponsibility. These three constitute the setting of the lies: they are the medium through which the propaganda is transmitted."

"Antivivisectionists" are charged by Mr. DeVoto with being inconsistent. For example, typical legislation introduced in Massachusetts prohibited experimentation on dogs and cats but made no mention of guinea pigs, rats and monkeys "which constitute the bulk of laboratory animals." "Get dogs out of the literature," he says, "and 'antivivisectionism' would perish for lack of funds."

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* New York and Massachusetts.

Veterans on Medical Care

Most readers of medical journals are familiar with the views of returning service physicians. Few of them have left any doubt as to their distaste for military service. Most, however, agree that the medical care given the soldier in the war just concluded was generally superior. They point out, however, that a vast majority of medical officers were civilian doctors serving in the armed forces for the duration of the war.

How do the veterans themselves feel about the medical care they received? A poll of a "representative group" is reported by Lt. Colonel Norman Nixon, Chief of the Medical Service, Regional and Convalescent Hospital, Santa Ana Army Air Base, in an article, "The Returning Serviceman—How Does He Stack Up Physically?" appearing in the May 1946 number of *The Military Surgeon.* Most of the article is devoted to the physical condition of the veteran. But Colonel Nixon also gives attention to what the veteran thinks of the medical care he received and what he prefers in the way of such service following his discharge.

Colonel Nixon writes:

> "An anonymous questionnaire submitted to a representative group of 1,200 returnees at Santa Ana shows that 6 per cent believe the medical service they received in the Army had been poor, 68 per cent thought it had been satisfactory, and 26 per cent called it superior; thus 94 per cent of the returnees were satisfied that the doctors, nurses, dentists, and all allied personnel working to maintain the health of the armed forces had done an adequate job.
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> "A break-down of the answers from those returnees in the hospital and those who had been previously hospitalized during their Army career showed that 34 per cent of these men believed their medical care had been superior in contrast to the only 24 per cent of those who had not required hospitalization. [See chart 1.]
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> "Because Army medicine is socialized medicine it seemed important to ask the returnees this question: 'After you return to civilian life what sort of medical care will you prefer for yourself and your family: (1) Private physician? or (2) A form of medical care insurance system in which, by paying a certain monthly sum, you and your family would be given all necessary medical care including the services of doctors, nurses, use of laboratory and X-ray facilities, hospitalization, dental care, prescribed drugs, etc.? Forty-eight per cent of the 1,200 polled were definite in their preference for a private physician while 42 per cent were in favor of some sort of medical health insurance; 10 per cent expressed no preference possibly because of their religion, because of their intentions of remaining in the regular Army, or because they didn't know. Here then are figures which should prove of interest to social workers and politicians. Even though the men had received the benefits of the most perfect set-up possible on a socialized medical basis, the majority still preferred the old system. However, an almost equal number approved some sort of insurance plan and it is this group which may become a potent force in moulding the public opinion in the postwar era."

CHART 1

The Returnee: His Health and Medical Care

	Total	*Processing Line*	*Hospital*
Number of Questionnaires	1191	892	299
Opinion of Army Medical Care			
Poor	6%	6%	6%
Satisfactory	68%	70%	60%
Superior	26%	24%	34%
Preference for Medical Care after the War			
Private Physician	48%	47%	53%
Insurance Plan	42%	42%	41%
Don't Know	10%	11%	6%

It seems that former medical officers and their former patients see eye to eye. Public officials would do well to take note of their views.

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"So to Endow One's Associates..."

Dr. Reginald Fitz of Boston recalls vividly a visit made by Dr. Osler to the Massachusetts General Hospital during the summer of 1910. It was a particularly hot, humid day in August when "we who were due to work in town over the weekend read a little enviously about some of our more fortunate friends who were in the country indulging in the frivolities of tennis or golf."

But Dr. Fitz and his associates were well rewarded when Dr. Osler put in his appearance. Details of the memorable visit are described by Dr. Fitz, then attached to the East Medical

Service of the Massachusetts General Hospital, in *The New England Journal of Medicine* for May 9.

"On that morning the visit started as usual. We were upstairs in Ward 30 and according to custom had started to move around in clockwise manner when in blew Osler. He came unannounced and unexpectedly. There was no need for any introductions, since Dr. Pratt knew him well and we house officers had heard him speak at the Harvard Medical School on a memorable occasion during the preceding year, so that we were familiar with his appearance—his short figure, his mustache, his keen eyes. Now we were at once delighted by him—in part, perhaps, because to have a distinguished visiting professor from England was by no means a usual happening, even for the East Medical Service; chiefly, because instead of observing the amenities by commenting on the weather or the state of our health, he immediately became part of us by asking, 'What have you got here?'

"Here was a young woman who had just been transferred from the surgical ward. She had entered the hospital for the removal of a fibroid; everything had gone smoothly for fifteen days, when she was suddenly seized with pain over the right lower chest and with dyspnea and fever. On physical examination, when we first saw her, her heart seemed a little displaced outward, and at the right base below the angle of the scapula was an area of dullness, with distant bronchial breathing and voice transmission that sounded unusually close to the ear. We believed that she had a pulmonary infarct. Dr. Brigham, whose privilege it was to present to the visit each morning the patients with their histories and physical findings, asked Dr. Osler what he thought of the situation. Osler did no more than demonstrate the technic of palpatory percussion by tapping the young woman's back with all the fingers of one hand, and having done so said, 'The resistance is quite marked, isn't it?' Dr. Pratt, recalling Oslerian teaching of the importance of increased tactile resistance in the recognition of hydrothorax, asked if he thought the patient had a collection of fluid in her chest. Dr. Osler was noncommittal; all he would say was that the resistance was striking, and finally that it might be well to insert a needle.

"Dr. Brigham performed this operation on the following day and removed 400 c.c. of fluid. The patient subsequently developed a recognizable phlebitis on the left leg and later in the right leg, and in the course of time made an uneventful recovery. None of us have forgotten the skill with which Dr. Osler demonstrated so nicely one of the essential signs of fluid, nor the tactful manner in which he suggested its removal."

Space does not permit inclusion of other incidents related by Dr. Fitz. However, he concludes his article with this statement:

"It is interesting how vividly Dr. Osler and his personality always impressed people who came in contact with him. To those of us who saw him that morning at the Massachusetts General Hospital thirty-five years ago, his visit seems like yesterday, and each recalls something different from it. . .

"This, I suppose, is the essential secret of successful clinical teaching: so to endow one's associates that each acquires some personal gift in the way of knowledge or approach to clinical problems that is not usual and settled but is inventive and, by adding new rhyme and reason to what was routine, is enduring."

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Measuring Medical Aptitude

Early in this century it was not a matter of selecting prospective medical students but of enrolling those who could be interested in becoming doctors regardless of their aptitude for medicine. Medical schools more frequently than not were forced to solicit students if they were to remain financially solvent. Fortunately those days are gone forever.

Dr. Worth Hale of Harvard Medical School, in an article entitled "The Measurement of Medical Aptitude" appearing in the *Journal of the Association of American Medical Colleges* for May, states that in a specific case in the "golden days when there were no tests of any kind" a class of 214 freshmen became 101 seniors. "The mortality rate," he says, "was unbelievably high and yet there appears to have been a good deal of forgiveness for ineptitude." One finds record cards filled with E grades although the pass mark was only 50. He reveals that one student card showed 5 failures in physiology, 4 in biochemistry, 2 in bacteriology, 2 in anatomy, 2 in therapeutics, 2 in clinical medicine, 1 in ophthalmology, and 1 in surgery, supported by 14 D grades during his four successful years.

What brought about a change was the fact that there were more applicants than vacant seats in medical schools. Methods of selection of necessity had to be devised. Among these was the yardstick by which aptitude could be measured.

> "To determine aptitude," Dr. Hale says, "we know well that many aspects of an applicant must be appraised: his character, his dependability, durability, his forcefulness and his vitality. He should have good health and a well integrated personality. He should be at ease working with people. His honesty should be of the highest degree. All of these attributes are a part of his personal makeup but they do not lend themselves to measurement in figures and percentages. Their appraisal must remain relative and be made by those who understand men, their virtues and frailties."

Dr. Hale discusses at some length the scholastic medical aptitude tests. How dependable are they in predicting scholarship in the medical school?

> "There is a certain halo about the applicant with high grades or test scores," Dr. Hale observes. "Grades are so definite and tangible. It is instinctive to believe that college grades truly represent an applicant's potentiality as a scholar in medicine. Probably that would be more true if the ceiling for grades were not so different at different colleges. We should be skeptical of them until proven by comparison with medical grades."

Dr. Hale and his associates analyzed the college scholarship records of some 540 Harvard medical graduates and about 300 war period students for whom they had both aptitude and Army General Classification Test scores.

> "Abilities at the college level," he explains, "may be measured by liberal arts grades, by grades in the sciences and by college honors at graduation. For study, the arts grades were divided into a high, a middle and a low group represented by the traditional A, B and C grades. The other evidences of ability, including medical scholarship, were by fourths."

It was found that among students with the highest college grades, test scores, or college honors, about two fifths ranked in the highest medical quarter. However, in this group there were approximately one sixth to one tenth in the lowest quarter in medicine. The average college student was fairly evenly spread in all four medical quarters. Dr. Hale here observes that "average grades are not so revealing as are grades at the top or at the bottom of the ladder." As to the lowest college grades or test scores, about two fifths are in the lowest medical quarter with one sixth in the highest medical school rank.

Dr. Hale makes it clear that tests are not intended to appraise the student's personal qualities other than his "ability to learn." Tests similar to those conducted by Dr. Hale on a nationwide scope have proved quite conclusively that applicants with high college grades have little scholastic difficulty in medical school but that low scoring students fare badly. The number of men classed as "dropped," "withdrew," or "repeaters," he said, "is large at low test levels and small at high levels."

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Will Social Revolution Engulf Us?

People are afraid these days and many are not reluctant to admit it. They fear many things, principally insecurity. They speak with foreboding about the future. They see nothing but storm clouds on the horizon and speak ominously of revolution. It is not surprising then that they are nervous, irritable, and difficult to get along with.

Physicians are not immune to fear. They, too, view with alarm and speak pessimistically of current trends and what they portend for the future. Not a few take the attitude, "What's the use of doing anything? It won't make any difference." Such a defeatist attitude is, unfortunately, infectious, and does not bode well for any group, medical or otherwise.

Now your Observer may be an incorrigible optimist. But he does not think that the situation is as bad as many people would have us believe. Of course we are in the midst of trying times. But maladjustments, confusion, and unrest have followed all wars. People do not know where they want to go or what they want to do. Really, there is nothing new about all this. Of course, we are going to have a social revolution if by that is meant a change of status and a new way of life for a large segment of our population. As a matter of fact, it is now in progress. But revolution is not necessarily characterized by physical violence.

If it is agreed that we are in the midst of a social revolution then medicine will not be passed by. In fact, medicine is going to change more than many physicians like to believe. But chances are that when the transition is complete, it will be the better for it. As a matter of fact, there is general agreement among medical leaders that changes are needed. The important thing is that they be wisely guided, and that is the obligation of the medical profession.

So in the opinion of your Observer, there is no need to worry about a social revolution. It is going on. If we sincerely and honestly fulfill our obligations to society, the revolution will take care of itself.

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Where's Your Hat?

The world today has more troubles than a dog has fleas. And to solve the innumerable problems which perplex them, its inhabitants have resorted to organizations of all kinds, having apparently come to the conclusion that in numbers there is strength. Unfortunately, unity and purpose, two very essential elements, are often conspicuous by their absence. But at least people are getting together for what they avow are the best interests of all.

While your Observer has heard of all kinds of organizations whose avowed purpose is to advance the welfare of humanity, it never dawned on him that there was need for one to discourage men from discarding their hats. But it appears that he was wrong; for in his mail the other morning, he learned for the first time of the Hat Research Foundation. It appears that the Foundation is deeply concerned lest people get the impression that hats are injurious to the health, and to prove otherwise, the Foundation sought the "opinions of 268 physicians in general and special practice in 41 cities throughout the United States."

In response to the question, "Do you recall reading any research or articles in medical journals giving information regarding baldness or health, in relation to wearing or not wearing a hat? (If 'Yes') Was the article published recently or some time ago?, 83 per cent of the physicians surveyed did not recall reading anything on this subject in medical journals; 13 per cent said they recalled reading something 'some time ago'; 3 per cent said they recalled reading something 'recently'; 1 per cent did not reply."

> "On the score of general health," the news release issued by the Foundation states, "besides blaming hatlessness as a cause of colds and heat prostrations, considerable numbers of the interviewed doctors also attributed other ailments to going without hats. Thus, 24 per cent of the doctors surveyed said hatlessness may contribute to eye trouble; 36 per cent said that hatlessness may contribute to ear trouble; and 48 per cent said going without a hat may contribute to sinus trouble. Smaller numbers expressed the belief that hatlessness may contribute to respiratory infections and local skin ailments.
>
> "Baldness, the doctors said, is likely to arise from a number of causes that have nothing to do with hats. Of those surveyed, 51 per cent mentioned hereditary tendencies and 12 per cent blamed diseases. Other causes mentioned were glandular conditions, dandruff, nutritional deficiency, unclean scalp, mental strain, and organic disturbances."

Now all of the "experts" who responded were not physicians. At least some of those quoted were not. Nor were all the quotations of recent origin. Several were culled from writings of rather ancient vintage. Bill Fallon, former coach at the University of Missouri, is reported as having said: "I always insist that athletes under my direction wear hats. Not wearing a hat, especially after taking a shower bath, or when there has been a sudden change in temperature, is one of the chief causes of the common cold. And a cold, we all know, can develop into many things, including grippe, sinus disease and infections of the nose. One function of the hat is that of making a man feel well dressed but another, and an equally important one, is to conserve the wearer's health. On neither ground is a man justified in going without a hat."

Dr. E. Lawrence Oliver, Clinical Professor of Dermatology at Harvard University, is quoted as saying: "Overexposure to sunlight is a cause of baldness. Just as exposure to the X-ray can cause complete falling out of the hair, continued exposure to the hot rays of the sun by the habit of going without hats may lead to it. There is more baldness than ever before because of this habit."

Dr. W. A. Evans, contributor of a health column in the *Chicago Tribune*, wrote back in 1935, "No one in temperate climate need go to great trouble to get sunlight in the midsummer, and taking it on the dome is worse than useless."

And finally, the Institute of Surgical Hospital News is quoted: "Experiments conducted with 50 hatless men and women, and 50 hatted men and women, in New York City brought out the following facts: Of the 50 who wore hats, less than 200 colonies of harmful bacteria and molds were found on the scalp, hair, eyebrows, ears, face, eyelids and other parts of the cranium and face after a short walk; while on the 50 who were hatless 950 harmful bacteria colonies were established. These included more than 35 different kinds of germs, molds and microbic life. Present were germs capable of producing such diseases as carbuncles, pimples, ringworm, diphtheria, running ears, eye-inflammation, eczema, streptococcus, ulcers, erysipelas, impetigo."

Certainly no further evidence should be necessary to convince even the most obtuse that they should keep their hats on, discarding them only for new ones.

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Car Shortage in Detroit One of the major headaches afflicting returning service physicians has been their inability to obtain automobiles. The Medical Society has aided several of them, but there are still doctors without cars. The other day a physician's wife called the Society's office. She said her husband had been released from the service last October, more than six months ago, but had been unable to obtain a car of any kind. Needless to say, this was one situation where the Society did everything possible to be of help, which wasn't really very much. For the car situation is worse now than it was a few months ago.

While there is undoubtedly a black market in automobiles, the fact is that due to the strikes and other domestic disturbances, there is a very limited quantity of cars available. Before these lines appear, it is to be hoped that the situation will have cleared up materially. But the experience many physicians returning to civilian life have had in endeavoring to obtain cars is one they will not soon forget.

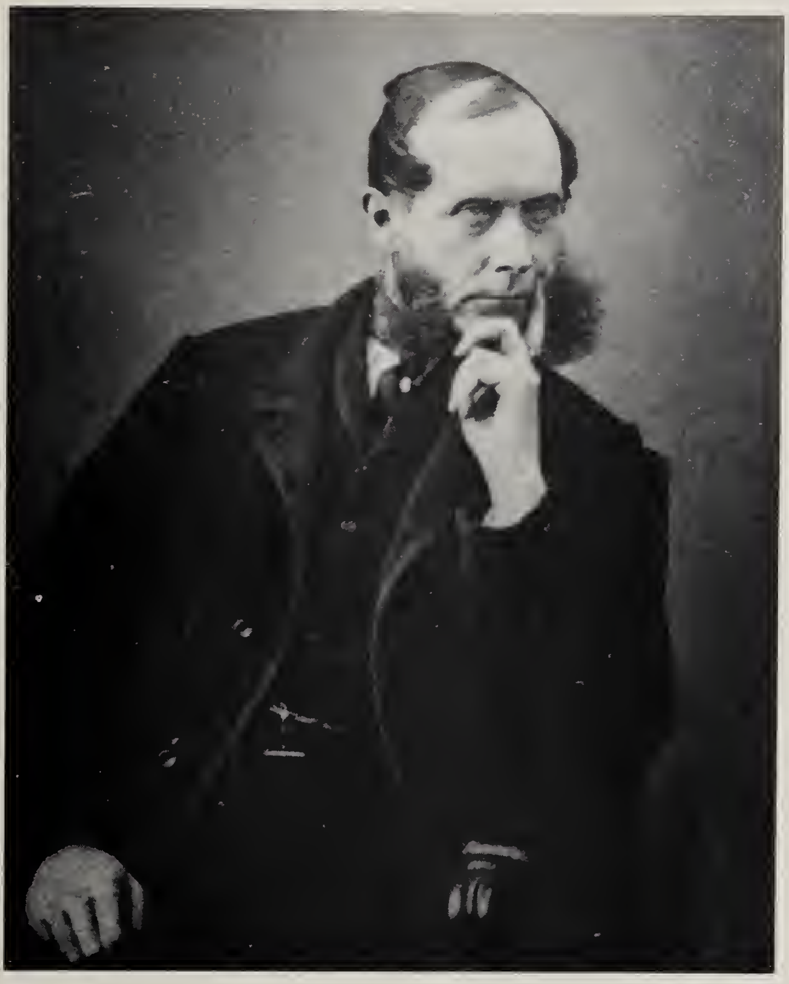
It was some comfort to your Observer, who has been very much concerned with this matter, to read the following item from the *Detroit Medical News* for June 3, 1946:

> "A considerable number of our medical veterans need cars; for obvious business reasons car agencies do not want cash deals and it seems necessary to have an old car to turn in. These medical veterans were asked to sell their cars to further the war effort when they went in the service, so that now they don't have anything to turn in. The combined strength of the American Legion, Veterans of Foreign Wars and the Wayne County Medical Society should be able to force the hand of the car distributor so that these M.D.'s can get cars. New cars are being sent all over the world but the doctors at home remain the forgotten heroes; they find it difficult to get enthusiastic about an Automotive Jubilee."

As has been stated, conditions should improve before many weeks have passed. If not, the Society will certainly apply more pressure, and perhaps call on the veterans' organizations to assist in obtaining cars so that doctors can carry on their practices. This matter is of direct concern to the public, and if necessary, they, too, should lend a hand.

(*Continued on page 411*)

Washington Physicians of Yesterday



JOHN FREDERICK MAY, A.B., M.D.

Dr. John Frederick May was born in Washington, May 19, 1812. He was the son of Dr. Frederick May (1773–1847), who in his generation was a leading physician in this city, and continuously served as president of both the Medical Society and the Medical Association of the District of Columbia from 1833 until his death in 1847.

John Frederick May graduated in medicine from the Columbian Medical College in 1834, and then spent over a year in European hospitals. Although also engaging in general practice, his specialty was surgery, and he was professor of this subject in the University of Maryland, 1837–39, Columbian Medical College, 1841–58, and Shelby Medical College, Nashville, Tennessee, 1858–61. About 1865 he removed to New York City, returning to Washington in 1880. He was a member of Garfield Hospital staff from 1884. He was a shrewd business man, and accumulated a fortune. He died May 2, 1891.

(Continued on page 412)

Veterans' Affairs

THE FUNCTIONS OF THE VETERANS ADMINISTRATION

The VA's job is to administer the benefits guaranteed by law to veterans and their dependents. Because it has a potential 20,000,000 customers, the VA is now running the largest insurance business, the biggest chain of hospitals, the greatest pension and claims service, and the most extensive education and vocational rehabilitation program ever undertaken. At present the VA is in the process of decentralizing its many functions in order to bring them closer to the veteran.

Medical Care and Hospitalization

The VA furnishes medical care for veterans with service-connected diabilities. Also, veterans with non-service connected illnesses who cannot pay for treatment are given hospitalization if there is a vacancy not required for a veteran with a service-connected disability. Since it has 20,000,000 potential applicants, the VA is now embarking upon the world's largest hospital construction program which will expand its present 106 hospitals to about 200. The most serious problem in the medical care of the veteran is the shortage in staff. There is actually a current surplus of hospitals in the country even though many of them are not of permanent construction. But hospitals are useless without doctors, nurses and other operating personnel. Hospitals convenient to medical centers can be staffed with specialists from top grade medical schools serving part-time; but hospitals built in isolated places must be furnished complete staffs of full-time doctors. To meet the great current load of veterans VA is resorting to:

(a) Taking over "surplus" Army and Navy hospitals.

(b) Utilizing allotted beds in Army and Navy hospitals.

(c) Contracting Beds in Private Hospitals. These contract beds will be available for veterans suffering from a service-connected disability when beds are not available in VA hospitals. Eventually all 48 states may have such contracts for beds in civilian hospitals.

The VA has the following services to aid veterans:

Neuropsychiatric Service.—Approximately sixty per cent of all hospitalized veterans are NP cases, for whom 33 hospitals now exist and 13 more will be constructed. In addition, patients in general medical and surgical hospitals will be treated in mental convalescent centers or special treatment centers. Mental hygiene clinics will treat those not needing hospitalization, in an effort to practice preventive medicine. A Residency Training Program is under way in association with Class A medical schools as well as in-service training for other grades.

TB Service.—The Veterans Administration is operating 14 tuberculosis hospitals and 36 tuberculosis departments in general and neuropsychiatric hospitals and treating some 7,000 patients.

To insure early diagnosis and prompt treatment of tuberculosis among the younger veterans, chest X-rays will be taken of each hospitalized patient at time of admission and each outpatient at time of scheduled examination, regardless of the disability for which hospitalized or examined. Periodic surveys of all general and neuropsychiatric patients at the end of each twelve months' residence in hospital have been authorized. Thus the chests of over a million veterans will be X-rayed annually. By this procedure alone, many lives will be saved and untold days of invalidism will be spared tuberculous veterans of this war.

Surgery.—Surgical facilities are provided in all hospitals of the Veterans Administration, tuberculosis hospitals, neuropsychiatric hospitals, and general medical and surgical. This comprises a surgical operating suite and necessary trained personnel to operate it. The latter consist of trained surgical nurses, attendants and surgeons. The surgeons consist of physicians on a full-time basis, specialists and consultants. These surgical treatment facilities are available continuously, 24 hours a day, seven days a week.

The surgical service comprehends the following groups or specialties: general surgery, orthopedic surgery, urology, ophthalmology, otolaryngology, plastic surgery, thoracic surgery, neurosurgery, gynecology, radiology, anesthesiology. The full-time surgical staff is supplemented by a part-time or fee basis specialist and consultant staff in the various specialties.

General Medicine.—There are 59 General Medical and Surgical Hospitals. Treatment for medical conditions is also furnished in the Tuberculosis and Neuropsychiatric Hospitals.

In addition, outpatient treatment for service connected medical conditions or conditions aggravating a service connected condition is being rendered in Veterans Administration regional offices and sub-regional offices. Medical treatment is being furnished domiciliary members in Veterans Administration homes.

A special Allergy Clinic is located at the Veterans Administration Hospital, Aspinwall, Pennsylvania, where stock allergens and autogenous allergens are obtainable. Problem cases of allergic conditions may be transferred to this clinic for special treatment.

Tumor Clinics are located in the Veterans Administration Hospitals at Hines, Illinois; Bronx, New York; Atlanta, Georgia; Washington, D. C.; Portland, Oregon, and Los

Angeles, California. Treatment by radium element and deep X-rays is available at all of these clinics, and radon implants can be supplied them upon request from the radium emanation laboratory at Hines. Tumor research units are in operation at Hines, Illinois and Bronx, New York, and a cardiac research unit at Washington, D. C.

Prosthetic Service.—VA's program for prosthetic appliances has been organized to provide efficient service and maximum benefits to veterans requiring artificial aids. It hopes to standardize these devices to incorporate the best features available. Effective June 15, the VA will buy the veteran any appliance he chooses, and already a nation-wide service system is being established which will render immediate repair service (up to $35.00), billing VA.

Reconditioning Services.—As the medical and surgical care of patients is carried out, an intensive course in rehabilitation will be given to veterans. The disabled must learn how to get up and down steps, off and on buses, cross streets and go shopping. For those patients who wish to further their education, a complete academic program has been organized. Veterans also will have a chance to explore vocational possibilities for post-hospitalization work while still a patient in a VA hospital. A staff of competent instructors assigned to the Rehabilitation Service will teach and assist.

Outpatient and Dental Service.—In order to render prompt and efficient service to eligible veterans in need of treatment on an outpatient basis, agreements or contracts already have been arranged with a number of states. It is anticipated that when this work is completed an agreement, together with a fee schedule, will be worked out for each state in the Union. In other words, after the veteran has contacted the VA representative, he may select his own doctor or dentist in his community and VA will pay the bill. This system eliminates travel on the part of the veteran and takes the heavy load off VA hospitals. At the present time there are medical outpatient agreements with Washington, Oregon, California, Kansas, Michigan, New Jersey and North Carolina.

In addition, the Veterans Administration has contracts with mental hygiene clinics, outpatient departments of hospitals, general medical and surgical clinics for treating outpatients. These agreements will supplement the work of VA's own full-time clinics in operation in regional offices and sub-regional offices and outpatient departments of our own hospitals.

EDUCATION

The providing of suitable training to restore the employability of service-disabled veterans is the basic responsibility in the education and training program. To promptly make available educational benefits to able-bodied veterans is a responsibility only slightly less basic. The policies and procedures of the Veterans Administration have been designed with these purposes in view. Every veteran of this war with other than a dishonorable discharge, and who had 90 days of service, all or a part of which was served after September 16, 1940, may receive from one to four years of schooling, depending on the length of service. His tuition, books, supplies and fees are all paid by the Government, up to $500 annually, and in addition, if he is a full-time student, he receives $65 a month living allowance if he has no dependents; $90 with dependents. He may attend any state-approved school whose standards he meets, including foreign universities, short courses in technical or trade schools, correspondence courses, flying schools, foreign language lessons, and many other types.

MISCELLANEOUS

Special Services.—The VA's Special Services is primarily concerned with the welfare and morale of veterans in hospitals and homes.

Construction and Supply Service. The VA's Construction and Supply Service is charged with the construction of all veterans' hospitals, attendants' quarters, etc., and also with equipping these facilities.

Loan Guarantee. The VA guarantees or insures eligible loans of veterans up to (1) $4,000 for real estate loans, (2) $2,000 for non-real estate loans, or (3) a prorated portion of either of these amounts for loans of both types or a combination. In any event, the maximum amount of guaranty or insurance available to any veteran for any purpose is $4,000. Eligible loans fall generally into three classifications—home, farm and business—and almost any loan under these categories may be guaranteed. VA does not give or lend money to veterans. It guarantees or insures a portion of loans made to veterans by financial institutions or by individuals within the above specified limitations.

Readjustment Allowance.—Program inaugurated in September 1944, authorized by Servicemen's Readjustment Act, provides financial aid to eligible veterans during critical period of readjustment to civilian life.

a. Unemployment Allowance: The VA administers the payment of a readjustment of up to $20 a week to veterans who are unemployed. Maximum period of entitlement is 52 weeks.

b. Self-employment Allowance: A veteran fully engaged in an independent enterprise for profit may receive benefits of up to $100 per month for a maximum period of 10$\frac{2}{5}$ months. Self-employed veteran is entitled to the difference between $100 and his net profit for the period benefits are claimed.

Insurance.—As of December 31, 1945, the VA has written in 5$\frac{1}{2}$ years almost as much life insurance as all private companies (400) have in force after 100 years of business.

All National Service Life Insurance originally is issued on the 5-year Level Premium Term plan, with the right to convert to permanent plans. The millions of veterans of World War II and those persons now entering the armed forces have an unusual opportunity to safeguard their financial future through National Service Life Insurance. Premium rates are low because the Government pays all losses traceable to the extra hazard of military or naval service and all operating expenses through separate appropriations. Every dollar of premiums collected is held in trust and invested at interest for eventual return in benefits to policy-holders or other beneficiaries.

Contact and Services.—The Office for Contact and Services is the link between the Veterans Administration and the public. All communications addressed to VA's Central Office, Washington, D. C., are processed by the Administrative Service,

(*Continued on page 412*)

News and Personals

The 95th Annual Session of the American Medical Association closed in San Francisco, July 5. Because many physicians combined attendance at the Assembly with vacation trips, the registration was unusually large. Official representatives of the Medical Society of the District of Columbia at the meetings of the House of Delegates were Dr. C. B. Conklin, Delegate, and Theodore Wiprud, Secretary of the Society.

Dr. Harrison H. Shoulders of Nashville, Tenn., was installed as President, July 2, succeeding Dr. Roger I. Lee, Boston. Among new officers elected at the final session of the House of Delegates were Dr. Olin West, Chicago, President-elect; Dr. Edward L. Bortz, Philadelphia, Vice President; Dr. George F. Lull, Chicago, Secretary; Dr. Josiah J. Moore, Chicago, Treasurer; and Dr. R. W. Fouts, Omaha, Speaker of the House of Delegates.

Dr. West's election as President-elect recognized his long services to the American Medical Association as Secretary and General Manager since 1922. He retired early in 1946.

Dr. Anton J. Carlson was awarded the Distinguished Service Medal for 1946. Dr. Carlson, who is Professor Emeritus of Physiology at the University of Chicago, has contributed many articles on investigations in physiology of the heart and circulation, gastric secretion, the nature of hunger and the glands of internal secretion. He is immediate Past President of the American Association for the Advancement of Science, Past President of the American Association of University Professors, the American Physiological Society and the Society for Experimental Biology and Medicine.

Members of the District Medical Society in attendance were:

Drs. Samuel A. Alexander, James I. Boyd, Tomas Cajigas, Elma B. Carr, Coursen B. Conklin, Samuel Dessoff, Harold R. Downey, Roy F. Dunmire, Walter Freeman, James N. Greear, Jr., William P. Herbst, Emil J. C. Hildenbrand, Herman E. Hilleboe, Oscar B. Hunter, Catherine W. Johnson, Sollie Katzman, Norman T. Kirk, Alvin B. C. Knudson, Joseph S. Lawrence, S. Arthur Linde, Philip Litvin, R. N. Manganaro, George H. McLain, Esther A. Nathanson, John M. Orem-Winfred Overholser, J. Winthrop Peabody, Carolyn S. Pincock, Glen Pincock, C. J. Potthoff, Joseph T. Roberts, Leland E. Stevenson; J. Ross Veal, Eugene R. Whitmore, and Theodore Wiprud.

CALENDAR OF MEETINGS

July 8	Program Committee, 17th Annual Scientific Assembly
July 11	Committee on Social Affairs, A.S.A.
July 26	Committee on Social Affairs, A.S.A.
July 29	Executive Board Finance Committee, A.S.A.

The 1947 Annual Session of the AMA will be held, beginning June 9, at Atlantic City.

The Convention of the Association of Military Surgeons of the United States will be held in Detroit on October 9–11. Because indications are that attendance will be unusually heavy, all members planning to take part in the meetings are urged to send in their reservations immediately so as to be sure of obtaining proper hotel accommodations. The Hotel Book-Cadillac will be the headquarters for the convention.

The Southern Psychiatric Association will convene at the Jefferson Hotel in Richmond, October 7 and 8. The last meeting of the Association was held in Nashville in 1941.

Philadelphia will be host to the **48th Annual Convention and Post-war Conference of the American Hospital Association** during the week starting Monday, September 30. The Philadelphia Commercial Museum, Exhibition and Convention Hall will be used for meetings and exhibits and the Bellevue-Stratford and Benjamin Franklin hotels for hotel activities.

Cancer research will be stimulated by grants-in-aid to several American universities in the total amount of $50,000, an amount which has been approved by the U. S. Public Health Service upon the recommendation of the National Advisory Cancer Council.

Among the schools to receive grants is **George Washington University.** Two separate grants will be made, one to provide $2,100 for a story of the effect of vitamin E on the growth and incidence of spontaneous and induced tumors in mice, under the direction of Dr. Ira R. Telford. The other will provide $2,500 for a program of study, under Dr. Chester E. Leesee, of the toxicity, metabolism, physiologic and pharmacologic actions of substances that may be useful in destroying cancerous tissue or in halting its growth.

Officials of **Doctors Hospital** have announced that plans are under way for a $1,500,000 addition to the present hospital. The addition, which will be a 10-story structure, will provide 250 more beds, principally for moderate-income patients. Dr. Oscar B. Hunter, Secretary of the Corporation, said construction is expected to begin this year and will take a year to complete. Furnishings will add $250,000 to the cost. The addition will be due east of the new Columbia Medical Building Annex, scheduled to be constructed beginning in September.

On June 16, 1946, members of the **American Society for the Hard of Hearing** voted to change the name of their organization to **American Hearing Society.**

Clara Barton Hall, St. Elizabeths Hospital's new, modern residence for 100 student nurses, was officially opened in ceremonies, July 16, on the Hospital grounds. Dr. Winfred Overholser acted as master of ceremonies. W. E. Reynolds, Commissioner of Public Buildings, who supervised the construction, spoke briefly.

Members of **Phi Delta,** high school sorority, presented a check, June 20, to **George Washington University** for $2,000 to endow a room in the University's new hospital in memory of Miss Roma Simon, a sorority member who died in May, 1945. The gift, presented by Miss Shirley Clayman, a Past President of the Sorority, was accepted for the Hospital by Dr. Walter A. Bloedorn, Dean of the School of Medicine.

NOTICE TO MEMBERS

The books of Group Hospitalization, Inc., will be open again to new subscribers for the Doctors Group, September 1. Applications must be in the hands of the Society's Secretary by August 20 or earlier. Please telephone District 3111 for application blanks and any information.

A new **Association of Undergraduate Practical Nurses** has been organized. This is the first attempt to organize practical nurses in the District of Columbia. The association already has 75 members. Its immediate goal is the licensing of all professional practical nurses. Elected President was Miss Mary E. Bednarick; Secretary, Mrs. Paul Baker.

Dr. Thomas Parran, Surgeon General of the United States Public Health Service, was unanimously elected President of the World Health Conference on June 20. The Conference met in New York during June to chart an international organization. Representatives of 67 nations were present.

Dr. Parran was nominated by Dr. Andre Cavaillon, Secretary General of the French Ministry of Public Health, who called the selection "the ideal solution to the problem of a president." Delegates of Egypt, Colombia, the Philippines, Great Britain, China and Norway made seconding speeches.

Upon taking the chair, Dr. Parran called for the help of every delegate in carrying out the projected global war on disease.

Honorary memberships in the Brazilian Academy of Military Medicine were recently bestowed upon **Major General Norman T. Kirk,** the Surgeon General of the Army, and **Colonel Leon L. Gardner, M.C.,** Director of the Army Medical Library, through the recommendation of Major General Florencio de Abreu, the Surgeon General of the Brazilian Army. Very few foreign doctors hold honorary membership in the Brazilian Academy of Medicine.

Dr. Hugh S. Cumming was awarded the Orden del Quetzal, one of Guatemala's high awards, by the Guatemalan Ambassador, Senor Jorge Garcia Granados, at a dinner, June 17. Dr. Cumming is Director of the Pan-American Sanitary Bureau. The Ambassador, in presenting the award, praised Dr. Cumming for his outstanding work for Latin America and Guatemala especially.

Dr. Thomas Parran, Surgeon General of the USPHS, spoke at a luncheon meeting, July 16, at the Plaza Hotel arranged by Mr. Spyros P. Skouras, President of the 20th Century Fox Film Corporation, in behalf of the National Arthritis Research Foundation. The meeting launched a campaign for raising the sum of $2,500,000 for the construction and equipment of the Foundation's research laboratories, to be located in Hot Springs National Park, Arkansas.

Dr. Daniel B. McCallum, Richmond Branch Medical Director of the Veterans Administration, has named three Washington specialists as consultants on his staff. They are **Dr. Ralph M. Caulk,** Associate Roentgenologist at Garfield Memorial Hospital; **Dr. James N. Greear,** Professor of Ophthalmology at Georgetown University School of Medicine; and **Dr. George M. Wyatt,** radiologist with the firm of Groover, Christie and Merritt.

Lt. Colonel Leo V. Schneider, M.C., A.U.S., returned to his position as Chief Medical Officer of the District Tuberculosis Sanatorium at Glenn Dale after having been in army service since 1942. Colonel Schneider was associated with the Sanatorium from its opening in 1934. He left to take his army commission in October, 1942, and recently served as tuberculosis consultant for the Army in Berlin.

Dr. Leon Gordon, Medical Director of the Metropolitan Police Boys' Club, was awarded an honorary gold police badge, July 2, by Police Superintendent Harvey G. Callahan for his work in connection with the Boys' Club. Dr. Gordon has served the Club since its organization about 10 years ago.

Dr. J. R. B. Hutchinson, Medical Director of the Acacia Life Insurance Company, was named Chairman of the Medical Section of the American Life Convention at the 34th annual meeting of that organization in Hot Springs, Va., according to an announcement, June 28. The position carries with it automatic membership in the A.L.C. board of directors. Dr. Hutchinson is a cardiac consultant on the Arlington Hospital staff.

The Board of Trustees of **Suburban Hospital,** Bethesda, Md., at its regular monthly meeting, June 26, appointed Dr. R. Bretney Miller and Dr. Darrell C. Crain to the attending staff in medicine, and Drs. Greenville B. Queen, Gilbert B. Rude. and John V. Dolan to the associate attending staff in medicine.

Dr. William D. Chase, an Associate Member of the Society, writes that he has accepted an appointment on the medical staff of the Veterans Hospital in Reno, Nevada. Dr. Chase, who served in the Army of the United States from 1943 to 1946, was discharged with the rank of Major.

Dr. Norman Q. Brill is one of 18 civilian neuropsychiatrists who were appointed consultants to the Secretary of War upon the recommendation of the Surgeon General. According to an announcement released by the Office of the Surgeon General, these consultants are former Medical Corps officers who served with distinction during the war. Their appointment was made as part of the Army Medical Department's program to maintain the highest standards of medical practice.

Theodore Wiprud addressed the interns and residents of Emergency Hospital, June 26. He outlined the history of the Medical Society of the District of Columbia with emphasis on its relationship to the American Medical Association.

Dr. William A. Howard has been appointed Physician-in-chief at the Children's Country Home at 18th Street and Bunker Hill Road, N.E. He replaces **Dr. Harry Ong,** who has resigned after many years of service to the Home. Dr. Howard, a graduate of Tulane University School of Medicine, was Chief Resident at Children's Hospital in 1937. During the war he was director of medical technical intelligence for the Army in the European theater. He held the rank of Lieutenant Colonel.

Drs. Elmer Klein and Roger S. Cohen have offered their services temporarily to Gallinger Hospital for two half days weekly each to help relieve the critical personnel situation in the Hospital's mental wards. With the approval of the District Commissioners they have arranged to serve only until the Hospital can build up its depleted psychiatric staff.

Stephen McDonough, Washington science editor of the Associated Press for eight years before the war, died June 29 after an emergency operation at the Mayo Clinic at Rochester, Minn. Mr. McDonough, who was 41 years old, was well known for his articles on medicine and was personally acquainted with many Washington physicians through his attendance at scientific meetings.

During the war Mr. McDonough was head of the technical information service of the Surgeon General's Office with the rank of Major. For the past six months he had been Managing Editor of *Modern Medicine*, published at Minneapolis. A graduate of the University of Iowa, he came to Washington after service with the Associated Press in the Des Moines, St. Louis and New York bureaus.

He is survived by a wife, Mrs. Mary Lou McDonough, and a daughter, Jane.

BOOKS RECEIVED FOR REVIEW

Acknowledgment is made of the following books which have been received for review:

Diabetes—A Concise Presentation. Henry J. John, M.A., M.D., F.A.C.P., Lieutenant Colonel, Medical Corps, Cleveland, Ohio. Pp. 300, illustrated. Price, $3.25. St. Louis: Mosby, 1946.

Physiotherapy. Thomas Francis Hennessey, M.D., Dean and Director, Massachusetts School of Physiotherapy, Boston, Mass. Pp. 23. Price, paper, 75 cents. Boston: Bellman, 1946.

Narcotics and Drug Addiction. Erich Hesse, M.D. Pp. 219. Price, $3.75. New York: Philosophical Library, Inc., 1946.

Review of the Fight against Tuberculosis in Wisconsin and Elsewhere, 1898–1946. Gustav Schmitt, M.D., Milwaukee, Wis. Pp. 80. Milwaukee: North American Press, 1946.

BOOK REVIEW

The Management of Fractures, Dislocations and Sprains. John Albert Key, B.S., M.D., Clinical Professor of Orthopedic Surgery, Washington University School of Medicine; Associate Surgeon, Barnes, Children's, and Jewish Hospitals, St. Louis, Mo., and H. Earle Conwell, M.D., F.A.C.S., Orthopedic Surgeon to the Tennessee Coal, Iron and Railroad Company and the American Cast Iron Pipe Company; Chairman of the Committee on Fractures and Traumatic Surgery of the American Academy of Orthopedic Surgeons; member of the Fracture Committee of the American College of Surgeons; Associate Surgical Director of the Crippled Children's Hospital, Attending Orthopedic Surgeon to St. Vincent's Hospital, South Highlands Hospital, Jefferson-Hillman Hospital, Children's Hospital and Baptist Hospitals, Birmingham, Alabama. Pp. 1322, illustrated. Price, $12.50. St. Louis: Mosby, 1946.

This is an internationally known book and has been used for many years as a textbook in a number of American medical schools. To laud the merits of such a book would be impossible and therefore this discussion will be more or less limited to constructive criticism.

This edition contains 1,322 pages and is well illustrated. It is divided into two parts: The first part is concerned with the principles and general aspects and the second part describes diagnostic methods and treatment of specific injuries. The forms of treatment are not original but are those that have been used by the authors and found reliable. As stated in the preface the authors take no credit for the methods of treatment selected and give credit to surgeons whose methods are described.

The section on compound fractures and war wounds is very good but even now has been outdated. The recommendations for use of internal fixation of compound fractures are questioned, even in this day of penicillin and sulfa drugs and early efficient débridement, except in some few special instances. It is stated that practically all compound wounds should be closed after early débridement with penicillin therapy. This is good treatment for the cleaner type of compound wounds, but those which are dirty or those with extensive laceration and tissue destruction should certainly be left open and thereafter be treated with early secondary closure. The use of skin-tight plaster in the early treatment of compound fractures should be discouraged. A great deal has been learned in the past two years in the treatment of severe infected compound fractures with tissue defects that has not been mentioned here. (It is possible that this book went to press before these procedures could be added.)

Many of the illustrations in this edition are better than those of previous editions, yet the quality of a number of them could still be improved. I noted illustrations of some obsolete methods such as Parham Band fixation in the treatment of fractures, transportation of spine fractures in hyperextension rather than flat. This last procedure is contraindicated in some types of spine fractures as has been so well described in this book. The use of pins introduced across fracture lines and left protruding through the skin has been generally discontinued as this introduces an easy route of infection. The use of board splints in the treatment of forearm fractures is rarely used and better results are obtained by the use of plaster of Paris. Many of the illustrations of forearm casts show the cast extending past the distal palmar crease, which is unnecessary and quite harmful as it limits finger motion.

Most fractures may be treated by any one of several good methods. In treating fractures of the carpal navicular bone two methods are described. The method shown and explained using the cast with the thumb hyperextended and in full abduction has resulted in contractures of the thumb with bad function of the hand. This treatment has been superseded by the use of the cast limited to the distal crease and with the thumb in a functional position as illustrated by Key.

The treatment of avulsion of the extensor tendon insertion at the base of the terminal phalanx as described has been replaced by a much better anatomical method. The discussion of treatment of fractures of the metacarpal bones by the use of the Banjo Splint with illustrations should be read and forgotten. It is of general opinion now that any mention of such a method with the fingers treated in extension should be only to condemn its use.

There are considerable changes throughout the book with description of newer methods and as a whole the revision is good. It is still the best American book on fractures, dislocations and sprains and is an excellent reference for the student, general practitioner and surgeon for whom it was written.

FRANK H. STELLING III, M.D.

REPRINTS RECEIVED

The following reprints have recently been received, for which due acknowledgement is made.

"Long-Range Dispersal of *Anopheles Quadrimaculatus.*" Don E. Eyles, Curtis W. Sabrosky and John C. Russell. Public Health Reports, October 26, 1945.

"The Therapeutic Effect of Promin in Leprosy." G. H. Faget and R. C. Pogge. Public Health Reports, October 5, 1945.

"Address Given at New Haven December 13, 1945." Morris Fishbein. Connecticut State Medical Journal, January 1946.

"The Age Factor in Disabling Morbidity, 1940–44—Experience in a Public Utility Company." W. M. Gafafer and Rosedith Sitgreaves. Public Health Reports, December 7, 1945.

"The Philosophical Background of Compulsory Health Insurance." Lowell S. Goin. California and Western Medicine, May 1945.

"The Status of the English Doctor." Major Clifford L. Graves. Journal of the American Medical Association, January 26, 1946.

"Cancer of the Prostate in Connecticut." Matthew H. Griswold. Connecticut State Medical Journal, February 1946.

"The Expansion of the Connecticut Cancer Program." Matthew H. Griswold. Connecticut State Medical Journal, January 1946.

"Gereology a Public Health Problem." Matthew H. Griswold. Connecticut Health Bulletin, August 1945.

"Legislation on Hospital Surveys Construction, and Licensing Considered by State Legislatures in 1945." Mary M. Guerin. Public Health Reports, December 21, 1945.

"Plague Infection Reported in the United States during 1944 and Summary of Human Cases 1900–44." Brock C. Hampton. Public Health Reports, November 16, 1945.

"Dental Caries Experience in Relocated Children Exposed to Water Containing Fluorine. I. Incidence of New Caries after 2 Years of Exposure among Previously Caries-Free Permanant Teeth." Henry Klein. Public Health Reports, December 7, 1945.

"DDT Residual House Spray—a Method of Malaria Control in Rural Areas." Frederick L. Knowles and Clinton S. Smith. Public Health Reports, October 26, 1945.

"An Epidemic of a Severe Pneumonitis in the Bayou Region of Lousiana. VI. A Comparative Study of the Viruses of Lymphogranuloma Venereum, Psittacosis and Louisiana Pneumonitis." C. L. Larson and B. J. Olson. Public Health Reports, January 18, 1946.

"Physicians on Coins." James B. McNaught. Stanford Medical Bulletin, May 1944.

"The Effect of Cocoa on the Utilization of Dietary Calcium." H. H. Mitchell and Janice M. Smith. Journal of the American Medical Association, November 24, 1945.

"Color Measurement and Its Application to the Grading of Agricultural Products." Dorothy Nickerson. Washington: U. S. Government Printing Office, 1946.

"An Epidemic of a Severe Pneumonitis in the Bayou Region of Louisiana. V. Etiology." B. J. Olson and C. L. Larson, Public Health Reports, December 14, 1945.

"Increase of Rat Infestation on Vessels Coming to New York," Robert Olesen; "Increase of Rat Infestation on Oil Tankers," Robert Olesen and J. L. Stone. Public Health Reports, November 2, 1945.

"Number of Vacancies for Full-Time Public Health Personnel in State and Local Health Departments July 1945." Thomas Parran. Public Health Reports, October 19, 1945.

"A Brief Account of Dr. James D. Trask. John R. Paul. Connecticut Teacher, December 1945.

"Acute Mesenteric Occlusion." John Roberts Phillips and Paul R. Stalnaker. American Journal of Surgery, February 1946.

"Tularemia—Attempted Transmission by Each of Two Species of Fleas: *Xenopsylla cheopis* (Roths.) and *Diamanus montanus* (Baker)." F. M. Prince and M. C. McMahon. Public Health Reports, January 18, 1946.

"Privine Dependence of Two Years' Duration." Lawrence E. Putnam and Robert P. Herwick. Journal of the American Medical Association, March 16, 1946.

"Malpractice Suits—the Rising Tide." Louis J. Regan. California and Western Medicine, February 1946.

"A Modified Rabbit Box Trap for Use in Catching Live Wild Rats for Laboratory and Field Studies." Curt P. Richter and John T. Emlen, Jr. Public Health Reports, November 2, 1945.

"Results of Providing a Liberally Adequate Diet to Children in an Institution. I. Acceptance of Foods and Changes in the Adequacy of Diets Consumed," Lydia J. Roberts, Ruth Blair and Marjorie Greider; "II. Growth in Weight and Height," Ruth Blair, Lydia J. Roberts and Marjorie Greider; "III. Blood and Urinary Excretion Studies Before and After Dietary Improvement," Helen Oldham, Lydia J. Roberts and Marjorie Young. Journal of Pediatrics, November 1945.

"Epidemiological Significance of Seasonal Variations in Rodent-Ectoparasite Distribution." A. S. Rumreich and Jean A. Koepke. Public Health Reports, November 30, 1945.

"A Study of the Rodent-Ectoparasite Population of Jacksonville, Fla." A. S. Rumreich and R. S. Wynn. Public Health Reports, August 3, 1945.

"The Eye as an Index of Health." Louis H. Schwartz. American Mercury, March 1946.

"The Release of Antigen from Certain Bacteria on Treatment with Ether." Charles C. Shepard. Public Health Reports, January 11, 1946.

"A Report of Damage to Fabric by Liquid Hydrocyanic Acid Gas in Fumigation." G. C. Sherrard. Public Health Reports, November 2, 1945.

"Bureau of Information, American Medical Association." M. Virginia Shuler. Wisconsin Medical Journal, January 1946.

"The Value of Physiologic Substrates in Sperm Migration in Selected Cases of Human Infertility—Observations on a Series of 106 Patients." Samuel L. Siegler. American Journal of Obstetrics and Gynecology, January 1946.

"Age and Sex Variations in the Prevalence and Onset of Diabetes Mellitus." Mortimer Spiegelman and Herbert H. Marks. American Journal of Public Health, January 1946.

"Dieto-Metabolic Urology." Paul Randolph Stalnaker. Texas State Journal of Medicine, September 1945.

"Standards for Psychiatric Hospitals and Out-Patient Clinics Approved by the American Psychiatric Association 1945–1946." American Journal of Psychiatry, September 1945.

"What Doctors Know about Ulcer." Joseph D. Wassersug. American Mercury, April 1946.

"Advance in Penicillin Therapy." Leona Alberts Wassersug. American Mercury, February 1946.

"Studies of the Acute Diarrheal Diseases. X D. Further Studies on the Relative Efficacy of Sulfonamides in Shigellosis." James Watt and Sam D.Cummins. Public Health Reports, November 16, 1945.

"A Modification of the Extralaryngeal Approach to Arytenoidectomy for Bilateral Abductor Paralysis." De Graaf Woodman. Archives of Otolaryngology, January 1946.

Virus Pneumonia—Wilner

(*Continued from page 387*)

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3. Laboratory aids in diagnosis of primary atypical pneumonia. Bull. U. S. Army M. Dept., 1946, **5,** 10.

In and Out of Focus—Observer

(*Continued from page 402*)

"How High Is Up?"

Inflation is already here where office rents are concerned. Many complaints have been received at the Society's office from members, especially from physician-veterans, that landlords are charging all that the traffic will bear. However, the District of Columbia is not unique, for it appears that renters are being gouged in nearly every community in the country.

Dr. Vincent F. Williams, writing in the May 11 number of the *Jackson County* (Missouri) *Medical Society Weekly Bulletin*, has something to say on this subject. He observes:

> "Most recent in the series of economic events which affect physicians are the rent hikes which seem general in Kansas City. Many members have received the ultimatum from their landlords that an increase—up to 100 per cent—in rentals for office space must be forthcoming, or else! Which seems a sizable jump in overhead.
>
> "Of course, there is no appeal to any agency on this matter, because business properties have no ceiling prices and we may expect the law of supply and demand to be the final arbiter. Thus at a time when many of our members are returning and are desperately in need of office space, we are confronted with the ugly head of

greed rearing itself! Yet everyone knows that such accommodations are at a premium now and this is the time to 'get it while the getting's good.'

"This policy is in line with similar well-known philosophies which have been exploited so forcibly and strikingly (the latter literally as well as figuratively) in the past few months and probably is to be expected. It will be interesting, however, to see this high-and-mighty attitude change one of these days, when there is a plethora of office space and a dearth of occupants. This will surely follow.

"We are reminded of a little boy sitting on a tea-kettle lid with his thumb plugging the spout and with the heat turned on high. Foolish, silly lad, he thinks he can resist the force of the steam-pressure within the kettle. He is riding for a big fall—after the explosion! This goes for the big-shot planners in Washington as well as the local exploiters of the supply-demand law.

"As a physician's overhead increases so must his income expand. Thus, he arrives at a higher level in the soaring spiral which can know but one end. Suddenly (and painfully) everyone will realize that there must be an end to all these doll-house dollars and then we will have a clear answer to: 'How high is up?'"

As Dr. Williams says, the landlord is having a field day. But to say that he is shortsighted is making a point of the obvious. Like most people, he never seems to learn. History and experience teach him nothing. Only when things level out will he come to his senses.

There are, of course, those from whom doctors rent their offices who are reasonable. They will win in the long run because physicians with whom they deal will not forget when the "boom" is over. Doctors are disinclined to move once established, which is one reason they are desirable as tenants. If treated fairly they can be counted on to remain indefinitely.

Fortunately, office space is now becoming more readily available in Washington, which is something to be thankful for even though the rents are often far out of line.

T. W.

Functions of Veterans Administration

(*Continued from page 405*)

Claims.—The adjudication of all claims for compensation, pension, insurance, and adjusted compensation filed by veterans, their dependents and beneficiaries.

Finance.—Under the jurisdiction of the Assistant Administrator for Finance are activities responsible for making and accounting for payments, benefits and otherwise.

Board of Veterans' Appeals.—It is the function of the Board of Veterans' Appeals to render final decisions on all cases appealed to the Administrator of Veterans' Affairs, wherein the claimant has been denied entitlement to a benefit for which he has made claim. It has no original jurisdiction, its work being similar to that of a court of appeals.

Solicitor.—The interpretation or construction of the several thousand statutes for the administration of the Veterans Administration is the responsibility of the solicitor. Some of these involve matters which have been in operation for many years.

The other main feature concerns the guardianship of incompetent veterans or other beneficiaries and of minor beneficiaries of the Veterans Administration. This work is performed in close coöperation with the State Courts and involves questions of finance, investments, social welfare, as well as legal questions covering the whole field of fiduciary relationship.

Washington Physicians of Yesterday—May

(*Continued from page 403*)

Dr. May contributed little to medical literature, and he was not very active in the affairs of the District Medical Society, so that his name is not prominent in the records and literature. Yet he was held in the very highest regard for his professional ability and character. He was about the first Washington physician to attain a reputation and large practice extending beyond the limits of the District of Columbia; he was in the very front rank of the surgeons of the United States; and he was rated as one of the most distinguished and brilliant physicians which this city has ever had. He was the first surgeon in Washington to perform an ovariotomy; and one of the first surgeons in America to perform a successful amputation at the hip joint.

He took a prominent part in the identification of the disfigured and almost unrecognizable corpse of John Wilkes Booth, killed after the assassination of President Lincoln. Dr. May had previously removed a large tumor from the back of the neck of Booth, leaving a large scar. By means of this scar he identified the body. In 1887 Dr. May wrote an account of this episode, entitled "The Mark of the Scalpel."

Although Dr. May in his time was so highly eminent, there is no personal remembrance of him in the present living generation. That is a pity; but *sic transit gloria mundi.*

John B. Nichols, M.D

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RECENT DEVELOPMENTS IN NEUROLOGY AND PSYCHIATRY

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This is a brief survey of only a modest part of the recent literature on neurology and psychiatry. The selection among the very significant publications was primarily guided by their practical implications.

Epilepsies.—Notable studies on the treatment of epilepsies were reported last year. Lennox[1] used successfully a new drug, tridione, in the following varieties: petit mal seizures (loss of consciousness for a few seconds, usually without any muscular movements or with some twitchings of the eyelids and rarely jerking of the head and arms); myoclonic attacks (jerkings of muscles of the arms without loss of consciousness); akinetic seizures (loss of postural tone with nodding of the head).

Out of 50 patients, of whom 46 were under 20 years of age, Lennox obtained cessation of seizures in 28 per cent, marked diminution of their frequency in 52 per cent, and no change in 20 per cent. In a few cases there were untoward effects, skin rash and photophobia.

A new anticonvulsant drug, hydantal, was used by Norman Ward Clein[2] in 10 patients. Particularly in combination with phenobarbital (0.02 Gm.) the treatment was very successful in convulsive seizures and also encouraging in petit mal. No toxic effects were observed. The average dosage was 3 tablets for adults and 2 for children.

Gerald Caplan[3] treated major epilepsy with electrically provoked convulsions. The underlying idea is that epileptic convulsions occur when accumulated excessive energy needs to be discharged. Considering that the convulsive attacks are unpredictable as to time and space, the idea is to prevent those spontaneous attacks in provoking discharges of energy under the most favorable conditions. Fifteen male epileptic patients received electric shock treatments once or twice a week for 3 to 9 months. In 11 patients the frequency of the convulsive seizures has markedly decreased. The author points out that the study was carried out in deteriorated psychotic patients and suggests the treatment be tried in non-institutionalized epileptics, particularly those who have seizures periodically.

Lumbago-Sciatica.—Extensive clinical and anatomicopathologic studies have led Lindblom[4] to conclude that in many cases complaints and symptoms of lumbago and sciatica are caused by nerve compression. The compression is usually outside of the vertebral canal at points of contact between nerves and vertebral discs, and is due to protrusion of a disc showing signs of degeneration.

Malaria, Cerebral Symptoms.—Sylvester McGinn and John P. Carmody[5] observed 16 patients with rather benign tertian malaria but with dominant cerebral symptoms. Coma occurred in every patient and convulsions in 8 patients. Thirteen patients recovered and 3 died. Autopsy revealed pathologic changes in the liver of each case. The treatment which proved to be effective was the intravenous injection of 7½ to 15 grains of quinine dihydrochloride in 1,000 c.c. of a 5 per cent dextrose solution.

Tetanus.—In the treatment of tetanus the tetanus antitoxin was successfully supplemented with penicillin, sulfa drugs, bromide and chloral hydrate in 2 cases by Russel Buxton and Rachelle Kurman.[6] Pentothal sodium intravenously (1 Gm. in 500 c.c. of normal saline) was effective in 1 case.[7]

Asymptomatic Neurosyphilis.—In a discussion of "asymptomatic neurosyphilis," i.e., abnormal cerebrospinal fluid but no clinical symptoms, Huston Merritt[8] stresses the fact that this form of neurosyphilis is the forerunner of the symptomatic neurosyphilis. If the cerebrospinal fluid remains normal 2 years after the luetic infection, neurosyphilis is not likely to develop later. Merritt therefore believes that many cases of general paresis and tabes dorsalis might be prevented if cerebrospinal fluid examinations were done in all syphilitic patients with positive serum tests and appropriate treatments were carried out in case the fluid is abnormal. The cerebrospinal fluid should be examined at the completion of the luetic therapy and again 2 years later. The frequency of symptomatic neurosyphilis increases within a few months following the luetic infection and reaches its height, 35 per cent, 18 months after the infection, after which there is a decrease. Out of 2,263 syphilitic patients, asymptomatic neurosyphilis was present in 9.5 per cent 5 years or longer after the infection.

Out of 200 patients with asymptomatic neurosyphilis, 110 were males and 90 females. Considering that parenchymatous neurosyphilis is 4 to 5 times more frequent in males than in females, one must admit that a large number of female syphilitic patients have an immunity against the development of parenchymatous neurosyphilis. It is interesting to note that in 2 per cent of the 200 patients the blood tests for syphilis were negative. The degree of abnormality of the cerebrospinal fluid is a valid criterion for prognosis and treatment.

Positive blood tests for syphilis in 22 out of 100 patients with malaria were observed by Bronstein and Gruber.[9] Twelve patients had either Kahn or Wassermann, or both, positive; in 10 the serologic reaction was doubtful. In all 22 patients the tests became negative within 30 days following the acute attack of malaria. Before the blood reaction became negative in 10 patients, there was a change in the Wassermann reaction and no change in the Kahn; the reverse was true in 3 cases. The inferences drawn from this study are: The diagnosis of syphilis should not be made on the basis of only 1 serologic test, particularly in patients who have had malaria. In the case of an acute attack of malaria, blood testing or retesting for syphilis should be done at least 1 month following the attack.

Prevention of Postlumbar Puncture Headache. This subject is discussed by McCarty and Raney[10] in a comparative study of 2 technics of lumbar puncture. In 85 men the lumbar puncture was done while they were lying on their sides, either in bed or on a treatment table. They remained in bed for 24 hours. Fourteen (16.4 per cent) suffered from headaches. In another group of 85 patients the lumbar puncture was done with the patient in a sitting position on a chair, and the patients were instructed to go about as they pleased, but not to lie down until the usual bedtime. Only four (4.7 per cent) complained of headache or backache. Recumbent position and mild sedatives brought relief. The authors feel that headaches following the lumbar puncture are caused by emotional disturbances which would increase intracranial pressure. Therefore, a simpler procedure is preferable.

The reviewer's comment is that lumbar puncture headache is generally regarded as due to leakage of the spinal fluid into the epidural space. Yet, emotional disorders may undoubtedly be contributing factors.

Head Injury.—The psychiatric aspect in head injury has again been brought to the fore in a number of recent studies. Alexandra Adler[11] finds that posttraumatic disorders are related to a number of factors, namely, advanced age, family responsibilities, pre-traumatic personality difficulties, occupational dissatisfaction, compensation problem, and the nature and development of the posttraumatic syndrome. Coma, amnesia, physical injuries lasting more than 6 months, long hospitalization and particularly headache and dizziness of long duration were associated with a high incidence of mental symptoms. In most cases anxiety symptoms dominated the clinical picture. Of less frequent observation were lability of mood, euphoria, and apathy, with intellectual impairment.

Jurgen Ruesch and Karl Bowman[12] studied very comprehensively late posttraumatic syndromes. Neurologic, psychologic and very extensive laboratory studies led the authors to the conclusion that personality difficulties more than brain damage determine the protraction of the posttraumatic condition, that the longer the duration of the posttraumatic syndrome, the less likely it is due to organic structural damage of the brain. Personality difficulties and adverse environmental conditons predispose to both the accident itself and the protraction of the posttraumatic syndrome. It is therefore eminently important to start psychiatric treatment at the very onset, in addition to the general medical therapy. Symptoms of an anxiety state, hysteria or a hypochondriacal attitude should be handled psychotherapeutically without delay.

Walter O. Klingman[13] on the basis of his war experience also stresses the importance of psychologic factors in injuries of the nervous system. He equally advisedly advocates early psychotherapy as soon as the patient's condition allows it, following head injury.

What appears to the reviewer less sound is the author's attitude that certain depressive reactions following trauma may be treated by convulsive therapy. Is it not adding insult to injury?

Psychoneurosis, Military Psychiatry, Psychosomatic Medicine.—A psychiatric study by Bela Mittelmann et al[14] of 450 patients admitted to various divisions of a general hospital revealed more or less serious personality disorders in 135 patients. By and large, the attending physicians have not recognized those mental conditions. Psychotherapy proved to be beneficial not only in essentially psychosomatic disorders but also in cases of infection and trauma; treatment of personality difficulties shortened the period of convalescence.

Carl Binger[15] discusses the relationship between arterial hypertension and personality disorders. He recognizes that patients with hypertension show personality difficulties—anxiety state, moodiness, tension. The psychoneurotic disorders may be traced to early childhood and throughout their adult life. Yet, Binger does not believe that those neurotic disorders are the cause of hypertension. He rather believes that both hypertension and psychologic disturbances are caused by some basic disorder, as yet unknown. Recognizing the indication for psychotherapy, he also points out that any medical or even surgical treatment of hypertension has strong psychotherapeutic influences.

Flind and Barber[16] discuss the role of psychogenic factors in rheumatic pain in a study of 120 patients admitted to the rheumatic treatment center for the Royal Air Force personnel. In many of those patients complaints of pain labeled as "rheumatism" were traced to early childhood and were associated with neurotic disorders. The authors stress the significance of psychogenic factors in either precipitating organic structural disorders in muscles, joints, or bones, or in provoking functional disorders, due to muscular tension. The patient's overconcern about the condition and his hypersensitiveness largely contribute also to the protraction of the illness.

In a comparative study of neurotic soldiers with and without gastric disorders of a "Neurotic Unit," Mitchell and Mullin[17] found that psychoneurotic disorders were more marked in the soldiers with gastric complaints. Their family histories revealed a higher frequency of gastric neurotics than in control group. The discharge rate among the gastric soldiers was higher than that of all residents of the "Neurotic Unit."

Carroll Spaulding Wright[18] reports case histories illustrating the important role of psychogenic factors in various dermatoses. Out of 25 cases of angioneurotic edema and chronic urticaria, in 17 emotional disturbances were regarded as significant etiologic factors. Psychogenic factors were also included among other causative agents in neurodermatitis, eczema, pruritus. In the author's opinion, the dermatologist should treat not only the skin condition but also the emotional disturbances of the patient. In serious cases of personality difficulties the treatment should be the coöperative work of the dermatologist and psychiatrist.

In a survey of psychosomatic disorders found in 13 million examinations of Selective Service registrations, Rowntree[19] reports the following significant data: The rejection for asthma nearly doubled; it increased for peptic ulcer about 50 per cent and for Negroes 2½ times as compared to peacetime rejection. Neurocirculatory asthenia was twice as frequent and in Negroes 5 times as frequent in 1944 as compared to 1943. However, reëxamination of 5,000 rejectees for cardiac conditions showed the inaccuracy of the contention that organic heart diseases are rare among rejectees; 50 per cent of them had rheumatic heart disease or valvular lesions.

The generally accepted thesis that neurotic reactions develop rather in mildly injured soldiers expecting to return to battle than in severely injured ones is challenged by Minski's experience[20] in a "Neurosis Center." Out of 54 patients 24 were severely wounded, 26 moderately and only 4 mildly. The psychiatric diagnoses were: anxiety state in 39, depression in 8 and hysterical reaction in 7. The personal and family histories revealed neurotic personality traits of long standing in most of the patients and members of their families. Among significant precipitating factors the author mentions worry over the family, handicap from the wound, and often witnessing a pal killed at the time the soldiers were injured.

Howard Rome[21] calls attention to the fact that among those discharged from the military service for neuropsychiatric disorders, a large number have remained in the United States and have never been in combat. At the same time he stresses the point that inadequacy in military life does not preclude normal adjustment in civilian life. It is eminently important to eliminate at induction and training centers potential psychiatric casualties. Treatment in the Navy is guided by the experience that the earlier the treatment the more effective it is likely to be. Psychiatric treatment is given at base, mobile and fleet hospitals in each theater of operation. Those requiring long treatment are returned to the United States. They are first treated in psychiatric divisions of general or convalescent hospitals. Those who need long observation and treatment are transferred to mental hospitals. What is particularly important to note is that hospitals and discharge centers try to prepare the patient for the discharge. He is given a thorough physical, psychologic and psychiatric examination. Qualified personnel advise the discharged as to the rights, benefits and privileges veterans are entitled to.

"Emotional albuminuria" in returned flying officers is described by Herbert R. Plass.[22] Out of 935 officers, 49 had albuminuria without any suggestion of organic disorders. There was albumin in the urine of 160 officers following a venipuncture; 111 of them had no albumin before the venipuncture. Emotional albuminuria is regarded as another manifestation of vasomotor or autonomic imbalance.

Under the title "Psychogenic Malaria," Bruce R. Merrill[23] describes psychoneurotic disorders in 6 Marines who had been in the South Pacific and had had benign tertian malaria with many remissions and recurrences. When they entered the hospital the patients were convinced that they had malaria. They had a chill similar to a malarial one, but without fever and sweating. They complained of headache, tightness in the throat, chest, heart palpitation, tremors, nausea, fears, diarrhea or constipation. Blood smears were negative. When advised that they did not have malaria they became resentful and hostile. Their premilitary life histories revealed serious personality difficulties of long standing with strong hostility towards father, resentment of authority in the family, school, and at work.

In active combat they found an adequate outlet for their hostility reactions, but they could not tolerate the usual rigid military discipline.

Child Psychiatry.--The effects of surgical operations (mostly tonsillectomies) on behavior of children is discussed by Levy[24] in a study of 124 children with behavior problems. The prominent reactions were anxiety and dependency in younger children, hostility and increased aggressiveness in the older children, fear of the dark, physicians, nurses and strange men. The author suggests to postpone operations, if possible, at least to the age of 3; to explain to the child the treatment, and to maintain the contact between mother and child before and following operation.

Michaels[25] justifiably criticizes studies indulging in finding correlations between behavior problems and electroencephalographic records.

The problem, whether or not epilepsy causes mental deterioration, was put to a test by Falk, Penrose and Clark.[26] In a study of 85 institutionalized epileptics in 1935, 1938 and 1944, the authors found no mental deterioration in 82; evidence of mental deterioration was found in only 3 psychotic epileptics.

Geriatrics. "The morbidity and mortality of patients with psychoses due to cerebral arteriosclerosis" was surveyed by Pollak[27] in 2,000 patients who died within the last two decades. The autopsies performed on all of them showed cerebral arteriosclerosis in 476. In only 25 per cent of these was death due primarily to arteriosclerosis. In nearly 50 per cent death was caused by pulmonary diseases. The average age of those patients who died from arteriosclerosis was 64, and from other causes, 72. Out of the 1,524 patients with psychoses, other than cerebral arteriosclerosis, only 8 per cent died of arteriosclerosis.

Benjamin Malzberg[28] points out the upward trend of admissions to New York State Hospitals of psychoses with cerebral arteriosclerosis. He states that the expectation of a psychosis with cerebral arteriosclerosis has increased at birth among males from 51.2 per 10,000 in 1920 to 113.9 in 1930, and to 191.6 in 1940. In females the increase is from 37.4 per 10,000 in 1920 to 95.0 in 1930, and to 186.3 in 1940. Considering this upward trend and the decreased mortality in the general population, Malzberg expects a further increase in the frequency of psychoses with cerebral arteriosclerosis.

Senile psychosis and pellagra is discussed by Meyersburg[29] in a report of 2 cases. The author points out that the neurohistologic changes in senility and pellagra overlap and that the clinical sypmtoms are also largely the product of both. However, in pellagra mental disorders usually appear after the skin and gastrointestinal disorders, but they also may be the only symptoms. The mental disorders in the early stage of pellagra are weakness, irritability, and muscular pain. Then come to the fore manic, depressive, anxiety, paranoid, hallucinatory reactions, and marked confusion. Intensive therapy with vitamin B products, either orally or parenterally in case of defective gastrointestinal absorption, and adequate diet have proven to be effective.

Alcoholism.—As pointed out by Karl M. Bowman[30] in the last year State Commissions have been set up and laws have been either passed or discussed to deal with alcoholism. The new Connecticut law appears to be the most constructive one, inasmuch as it is based on the recognition that alcoholism is a disease. In the treatment of alcoholism, therapeutic procedures based on the conditioned reflex knowledge may be helpful in certain alcoholics, but psychotherapy and adequate change in the environment constitute the essential treatment.

The adjustment of children of alcoholics is discussed by Anne Roe[31] in a comparative study of 36 foster home children of alcoholic parents with 25 foster home children of non-alcoholic parents. The children of the alcoholic parentage were as well adjusted as the children of the control group.

Carney Landis,[32] in a critical appraisal of the effect of prohibition of the sale of alcoholic beverages on the frequency of alcoholic psychoses, uses material from New York State Hospitals, some of which dates back to 1888. This study does not substantiate the claim that prohibition will diminish admissions to mental hospitals for alcoholic psychoses.

Martin Gross[33] discusses the relationship between the function of the pituitary gland and alcoholic intoxication. He believes that some of the symptoms of alcoholic intoxication are due to dysfunction of the pituitary gland caused by vitamin deficiency.

Treatment.—That the chronic use of benzedrine may not be innocuous is illustrated in a case reported by Norman and Shea[34]: An individual who turned from alcohol to benzedrine gradually increased the daily intake up to 250 mg. over a period of 5 years. The result was a typical picture of paranoid schizophrenia. It rapidly cleared up within 30 days with cessation of the medication.

The hypoglycemic shock therapy has in recent years been nearly generally superseded by convulsive treatment, the reason being that insulin treatment requires much of the doctors' and nurses' time, and above all, that the initial extremely favorable reports on the whole have not been substantiated. However, a recent, very comprehensive study[35] of insulin shock therapy in New York State Hospitals from January 1937 to July 1942 is much in favor of the treatment. The therapeutic results of insulin treatment of 1,128 schizophrenics were compared with those observed in 876 schizophrenics under routine hospital treatment. In the group of patients treated with insulin 79.5 were discharged as against 58.8 per cent among the other patients. Paranoid patients appeared to respond particularly well to insulin: 79 per cent were discharged as compared to 52 per cent in the group without any specific therapy. Patients without insulin treatment stayed longer in the hospital than insulin-treated patients. There was a saving of 9½ months of hospitalization for patients who received insulin treatment.

These results appear to the reviewer encouraging enough to justify insulin treatment in cases not responding to the usual hospital care.

In a survey of the effects of insulin treatment in schizophrenia, Gralnick[36] points out that in early treatment the remissions are of better quality and more stable. Most of the patients who remained well during the 7 years of follow-up received their treatment within the first year of their illness.

A survey of the "Use of Shock Therapy in 305 Mental Hospitals" by Kolb and Vogel[37] shows that electroshock therapy has generally taken the place of the metrazol therapy.

The electric shock treatment according to the Ziskinds[38] shortens the duration of depressions but does not increase the frequency of recoveries and does not affect recurrences. Other authors point out the high frequency of relapses following convulsive therapy.

A very exceptional complication, "Cerebral Fat Embolism after Electrical Convulsion Therapy" in a man 53 years old, was reported by Meyer and Teare.[39] The patient collapsed 20 minutes after the first convulsive treatment and despite intensive stimulants died 20 minutes later. Autopsy revealed no fractures. The most significant findings were numerous fat emboli throughout the cerebrum and cerebellum, more in the gray matter than in the white.

In another fatal case following 1 convulsive treatment, death was attributed to excessive vasomotor stimulation and consequent circulatory disturbances. The schizophrenic woman, 42 years old, following the convulsion never regained consciousness and died $19\frac{1}{2}$ hours later. The autopsy did not reveal any macroscopic changes.

Pacella and Barrera,[40] in a study of over 500 patients who received electroshock therapy, observed attacks of generalized convulsions in 2 patients $6\frac{1}{2}$ to 8 weeks following the treatment. They had never had convulsions prior to treatment. Their pretreatment electroencephalograms were abnormal. A great many patients had abnormal records but had no spontaneous convulsions. Yet, these 2 cases suggest that in persons predisposed to convulsions the convulsive treatment may precipitate spontaneous seizures.

In the evaluation of the efficacy of electroshock therapy, the time of appraisal is in Alexander's study[41] a very important factor: Immediately following the completion of the treatment the evaluation was: social recovery in 84 per cent of involutional psychoses, in 93 per cent of the manic depressive psychoses, and in 83 per cent of the schizophrenic patients. One month after the termination of the treatment, the estimation was: social remission in 41 per cent of the involutional psychoses, in 47 per cent of the manic depressive, and in 63 per cent of the schizophrenic patients. Leon Salzman,[42] in a study of 180 patients readmitted to St. Elizabeths Hospital, noted that "electroshock therapy tended to decrease the readmission interval and may possibly produce some deterioration."

In a recent clinical and electroencephalographic study by Katzenelbogen and Mosovich[43] in patients of St. Elizabeths Hospital who received electroshock treatment, some of the results are worthy of note:

1. Out of 82 patients, in 58 the electroencephalographic records taken the day following a treatment showed the typical pattern of cerebral dysrhythmia. Twenty patients showed the same pattern 10 months after the completion of the treatment. Thus, electrically provoked major convulsions are apt to provoke more often than not specific changes in the electric potentials, known as patterns of cerebral dysrhythmia, which are so closely associated with convulsive disorders and are even regarded by some as the very basic cerebral processes responsible for convulsive disorders.

2. The frequency of cerebral dysrhythmia appears to depend largely on the number of treatments. It is therefore suggested that electroshock treatments should be limited to as few as possible.

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PENICILLIN THERAPY IN THE PRACTICE OF INTERNAL MEDICINE AND PEDIATRICS*†

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Penicillin has by now been employed for a sufficient period of time so that its effectiveness in certain diseases is well established. As a result of our experience in the treatment of over 485 cases at the Gallinger Municipal Hospital, and in the private practice of one of us, we have formulated certain concepts as to the usefulness of this antibiotic, the optimal doses to be employed, and the results to be expected. The present paper is a brief summary of our experience in the treatment of infections caused by bacteria which are sensitive to penicillin *in vitro*. We have grouped the different infections according to whether penicillin (1) produces a material change in their prognoses as compared to preëxisting therapeutic régimes, (2) causes only a slight change in the prognosis, or (3) does not affect the prognosis at all.

Diseases in Which Penicillin Materially Alters the Prognosis

Subacute Bacterial Endocarditis.—Subacute bacterial endocarditis, a disease which was once considered almost uniformly fatal, is now regarded as curable. Every patient in whom a definite diagnosis has been established by obtaining two or three positive blood cultures should be given the benefit of treatment, since it is our experience that patients may recover no matter how poor the prognosis may appear to be. If the patient's condition permits, the penicillin sensitivity of the infecting organism should be determined before treatment, so that the dosage may be more rationally determined and the phenomenon of increasing resistance of the organism may be recognized, if it occurs. In our opinion, all patients should be treated for 8 weeks, even though all evidences of infection have disappeared before that time. While some investigators recommend shorter terms of therapy, others,[1] as well as we,[2] have shown that relapses and their consequences have been eliminated by this plan. Doses varying from 200,000 to 300,000 units of penicillin per day given by continuous intramuscular infusion or intermittent injections at 2- to 3-hour intervals are usually sufficient to control the infection. However, if positive blood cultures persist or if the patient continues to show signs of infection, the dosage must be increased. One of our patients required 1,000,000 units per day, and others[3] have reported the use of 10,000,000 units over a 24-hour period before the infection was controlled. Twenty patients with subacute bacterial endocarditis were treated in the manner discussed with a resultant recovery rate of 70 per cent. None of these patients have suffered relapses, although they have been followed for periods up to 24 months.

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Acute Endocarditis.—The principles of therapy outlined above for subacute bacterial endocarditis should be employed in the treatment of the acute form also. When the causative organism is a staphylococcus, higher doses should be given, since this organism is likely to become resistant. At least 500,000 units a day should be administered initially. The prognosis in the acute variety is poorer than in the subacute type. A complete review of the treatment of 8 cases, in 3 of which the patients recovered, is being reported elsewhere.[4]

Staphylococcal Bacteremia.—Although sulfonamides have been somewhat efficacious in the treatment of staphylococcal bacteremia, significant results were not obtained until penicillin was introduced. The dosage of penicillin administered depends on the sensitivity of the organisms and the clinical response. In most cases 500,000 units a day are required. This therapy should be continued for at least 1 week after the blood cultures have become negative, the temperature has reached normal limits, and all signs of toxicity have disappeared.

Pneumococcal Meningitis.—When sulfonamides alone were used, about 90 per cent of the patients with this disease died. Penicillin has reduced the fatality rate to approximately 50 per cent. The plan of therapy which we have used is to employ sulfonamides and penicillin systemically plus penicillin intrathecally. Sulfonamides were administered in full therapeutic doses, and at least 200,000 units of penicillin were given parenterally each day. Twenty thousand units of penicillin were instilled intrathecally every 12 hours for the first 3 doses and every 24 hours thereafter. The patients who developed clinical evidence of block in the spinal canal or the few who failed to show general improvement were given penicillin intracisternally or into the ventricles. The latter method was preferred, since the procedure is less dangerous. In general, intrathecal penicillin was discontinued when the spinal fluid was free of organisms and had a normal dextrose content, and the parenteral penicillin about 1 week later unless continued fever indicated the need for more prolonged parenteral and intrathecal treatment. The sulfonamides were continued for about 7 days after penicillin therapy was stopped. We have treated 59 patients with a resultant recovery rate of 41 per cent.

Staphylococcal and streptococcal meningitis, when encountered, should be treated in a similar manner.

DISEASES IN WHICH PENICILLIN IMPROVES THE PROGNOSIS

Pneumococcal Pneumonia and Empyema.—Penicillin has been so effective in the treatment of pneumococcal pneumonia that deaths rarely occur except in patients who develop complications, have other diseases, or are seen late in the course of their illness. A review of the recent literature suggests that good results are obtained in moderately ill patients, whether they are treated throughout the day and night or only during the waking hours. Most investigators agree, however, that severely ill patients should receive continuous therapy for at least 24 hours. We have treated 170 adult patients by the continuous method, giving 15,000 units intramuscularly or 75,000 units orally at 3-hour intervals until the patient was afebrile for 48 to 72 hours. Only 14 or 8.2 per cent of these patients failed to recover.

Those patients who developed empyema as a complication of penumococcal pneumonia, or as a result of pleural invasion by any penicillin-sensitive organisms, were given a 7- to 10-day trial of 30,000 to 50,000 units of penicillin administered by instillation into the pleural space on alternate days. This was supplemented by intramuscular therapy if there was evidence of active underlying disease. When clinical and bacteriologic evidence of improvement did not appear within 10 days surgical drainage was instituted. Three of the 12 patients treated in this manner recovered without surgery.

Diseases Caused by Beta-Hemolytic Streptococci.—One of the few contagious diseases in which penicillin therapy seems to be of definite therapeutic value is scarlet fever.[5] We have compared a group of 60 patients who were given penicillin with a group that received antitoxin or sulfonamides or both, and with a group of patients who were treated symptomatically. The penicillin-treated patients made a more rapid recovery than the symptomatically-treated patients, and septic complications which were present in both of the other groups were eliminated in the penicillin-treated patients. The recommended dosage-schedule is 200,000 units per day for at least 5 days. Under this same régime patients with streptococcal sore throat and carriers of hemolytic streptococci were rid of the organisms and all symptoms of pharyngitis or tonsillitis. Four patients with erysipelas made a prompt recovery when treated in a similar manner.

Purulent Arthritis and Osteomyelitis.—The prognosis as to the morbidity, degree of disability and mortality in the streptococcal, staphylococcal and pneumococcal arthritides has been greatly altered by the introduction of penicillin. A complete review of this subject has been published by two of us.[6] A study of 8 patients revealed that intra-articular injections of 50,000 units every other day or 100,000 every 3 days, together with parenteral administration of at least 200,000 units daily as long as any extra-articular foci of infection were present, yielded the best results.

The need for surgery was eliminated in 5 of 7 patients with acute osteomyelitis of the staphylococcal variety, whereas the other 2 patients were not benefited by penicillin until drainage was performed. Doses of 200,000 to 500,000 units of penicillin intramuscularly per day were given for periods of 3 to 6 weeks. Consistently good results were observed in all of the patients who received 500,000 units per day. Conversely, among 5 patients with chronic osteomyelitis only 1 was benefited by antibiotic therapy.

Gonococcal Infections.—Twenty-five thousand units of penicillin given every 3 hours were found to be curative in the 10 patients with gonococcal arthritis who were treated for 5 to 10 days, whereas 8 who were treated for only 1 to 3 days were unimproved.[6] Although there are reports which recommend shorter courses of penicillin, we feel that the therapeutic period should not be less than 5 days and should extend over a longer period if evidences of active infection persist. Those patients who had genitourinary infections as well as an arthritis were cured of the former in 24 to 48 hours. Children with uncomplicated gonococcal vaginitis or urethritis recovered on the same régime within 24 hours.

Infections of the Skin and Subcutaneous Tissues.—This type of infection, which includes local abscesses, cellulitis, carbuncles and impetigo, will usually respond to 200,000 units of penicillin per day given for a 5- to 7-day period. All 19 patients who received these doses made a prompt recovery.

Vincent's Angina.—Vincent's angina is amenable to either local or parenteral therapy. The course of the illness is shorter, however, when parenteral therapy is employed. Fifteen thousand to 25,000 units given intramuscularly every 3 hours for 1 day will control most infections. Others will not disappear until therapy is continued for 2 to 4 days, or until the local dental measures, such as scaling of the teeth and curettement of the granulation tissue, are instituted. Recurrences or relapses may be cured with a second course of similar therapy. Oral penicillin in doses of 50,000 to 75,000 units every 2 to 3 hours over a 3- to 4-day period is as effective as 1 day of parenteral therapy. The penicillin may be administered continuously over the 24-hour period or during the waking hours only.

TABLE 1

Plans of Penicillin Therapy for Various Infections

DISEASES	DOSES OF PENICILLIN RECOMMENDED*	NUMBER OF PATIENTS TREATED	RECOVERED	DIED	UNIMPROVED
Diseases in which penicillin materially alters the prognosis					
Subacute bacterial endocarditis	200.000 to 300,000 units per day	20	14	6	
Acute endocarditis	500,000 units per day	8	3	5	
Staphylococcal bacteremia	500.000 units per day	9	8	1	
Staphylococcal meningitis	†20.000 units intrathecally once or twice per day	2	1	1	
Pneumococcal meningitis	200.000 units per day	59	24	35	
Diseases in which penicillin improves the prognosis					
Pneumococcal pneumonia	15.000 every 3 hours or 75.000 every 3 hours orally	170	156	14	
Empyema	30.000 to 50.000 units for each intrapleural injection	12	3		9
Diseases caused by beta-hemolytic streptococci					
Scarlet fever	200.000 units per day	60	59		1
Streptococcal sore throat		15	15		0
Erysipelas		4	4		0
Gonococcal infections					
Arthritis	200.000 units per day	18	10		8
Genitourinary		35	35		0
Purulent arthritis	200,000 units per day 50.000 to 100.000 units for each intra-articular injection	8	6		2
Osteomyelitis					
Acute	500.000 units per day	7	5		2
Chronic		5	1		4
Infections of skin and subcutaneous tissues	200.000 units per day	19	19		0
Vincent's angina	120.000 units per day	6	5		1
Otitis media	200,000 units per day	15	14		1
Bronchiectasis and lung abscess	200.000 units per day	13	0		13

* To be given by the intramuscular route unless otherwise indicated

† Full therapeutic doses of sulfonamides

Acute Otitis Media.—Penicillin has been used extensively in the treatment of middle-ear infections, because the most frequent causative organisms are hemolytic streptococci, staphylococci, and pneumococci. Those infections caused by staphylococci are often more persistent and refractory to therapy than those caused by streptococci and pneumococci. We have found that, although smaller doses may be ineffective, 15,000 to 25,000 units given intramuscularly every 3 hours for at least 48 hours after all signs and symptoms have disappeared, is superior in adults and older children to other types of therapy. The response is less consistent in infants, especially when diarrhea is a complicating factor. Careful observation must be maintained during the treatment period for the development of mastoiditis and other complications which may require other specific therapy.

Bronchiectasis and Lung Abscess.—In our experience with 13 patients parenteral penicillin is only of temporary value in bronchiectasis and lung abscess. Patients with bronchiectasis which is not amenable to surgery, however, should receive courses of penicillin in doses of 25,000 units every 3 hours during periods of exacerbations. Patients with lung abscesses should be given the benefit of 6 to 8 weeks of similar therapy if there is evidence of improvement within this time. An occasional patient with acute lung abscess will recover on penicillin therapy. The chief indications, however, for the use of penicillin in these pulmonary conditions are to control a superimposed pneumonitis and as a pre- and postoperative measure.

Diseases in Which Penicillin Apparently Does Not Change the Prognosis

There are certain infections in which, despite the low *in vitro* sensitivity of the organism to penicillin, its value is limited.

Tetanus and Diphtheria.—Penicillin has no effect on the course of patients with tetanus and diphtheria except to control pneumonia and other secondary infections that are present. Penicillin does not neutralize the toxins and should not be substituted for antitoxin. Recent investigations,[7] however, have suggested that diphtheria carriers may be promptly freed of the organism by penicillin therapy.

Meningococcal Infections.—Penicillin was found to be less effective when given both intrathecally and parenterally in meningococcal meningitis than the sulfonamides alone. The excellent results obtained when sulfadiazine or sulfamerazine are used[8] make the routine use of penicillin unnecessary. In severe cases of meningococcemia or meningococcal meningitis penicillin may be given in addition.

Table 1 summarizes our plan of penicillin therapy for various infections and presents the results of the treatment of our cases.

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PAPILLARY CYSTADENOCARCINOMA OF THE OVARY

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CARCINOMA of the ovary, including both primary and secondary types, is relatively frequent, since the ovary ranks second only to the uterus as the seat of cancer in the female reproductive organs. A study of salvage rates will also show that patients with cancer of the breast, cervix and rectum fare better than those with cancer of the ovary. With these facts in mind and with the cancer crusade increasing in tempo, it might be apropos to re-focus the attention of the medical profession on what Dr. H. S. Crossen[1] has so aptly phrased the menace of silent ovarian carcinoma.

Because of the heterogeneous character of ovarian neoplasms, only such cases will be discussed as fall into the category of papillary cystadenocarcinoma, both serous and pseudomucinous. This is by far the most common kind of malignant growth and nearly always arises from malignant degeneration of a cystadenoma. Indeed, the morphologic transition from the benign to the malignant in a series of cystadenomas and adenocarcinomas is so imperceptible as to defy the wisest of pathologists to draw the exact line of division. In order still further to narrow the field and thus to avoid confusion, the primary solid carcinoma, as well as the granulosal-cell carcinoma, the less frequent dysgerminoma and the rare arrhenoblastoma, the latter three of which are of relatively low malignancy, has been excluded.

Meyer[2] concludes from the collective statistics of many authors that ovarian cancer constitutes 14.9 per cent of all ovarian tumors. The growth may be solid or cystic, the latter variety being the more common.

Whether a primary cystic ovarian carcinoma is malignant from the beginning or develops in a previously benign cyst is a debatable question. However, it can be said that roughly 5 per cent of all pseudomucinous cysts and 50 per cent of the serous papillary variety undergo malignant degeneration.

A papillary cystadenocarcinoma is characterized by intracystic and extracystic, delicate, frond-like excrescences. Bilateral in 35 per cent of the cases, particularly in its extracystic form, the lesion is associated with peritoneal implants and with ascites.

The disease which is insidious in its onset can occur at any age. In Pemberton's series[3] the youngest was 26, and the oldest, 86. The average age was 49. Sixty-one per cent occurred between the ages of 40 and 60. Unlike the development of cancer in the uterus, cervix and breast, which is frequently preceded by a period of warning, the growth of ovarian carcinoma is essentially a silent one, devoid of symptoms which indicate to the patient that a serious process is present. Usually the patient presents herself after a short period of local symptoms, when the growth is already so advanced as to be inoperable. Frequently the only symptom of which the patient complains is low abdominal discomfort. Occasionally a little bloating, abdominal distention, or frequency of urination occurs. At times the patient presents herself because of some other condition, not suspecting that there is anything wrong with her pelvic organs.

Prior to the menopause there is no well defined diagnostic connection between this type of ovarian carcinoma and menstrual abnormalities.

After the menopause any flow should make one suspicious of an endometrial involvement or a neoplasm of the ovary.

A much better appreciation of the gloomy outlook for patients suffering from carcinoma of the ovary can be acquired by a study of salvage rates or 5-year cures. As reported by various authors,[4] these range anywhere from 10 to 50 per cent.

In Pemberton's series,[3] 114 patients with adenopapillary carcinoma were treated more than 5 years, and 37, or 32 per cent, lived 5 or more years after treatment. In this group, 90 with serous adenopapillary carcinoma were treated more than 5 years, and there was a 5-year salvage of 25, or 27 per cent. Of the 24 patients with pseudomucinous adenopapillary carcinoma treated more than 5 years, 12, or 50 per cent, survived a 5-year period.

Meigs[5] reported 147 cases of ovarian cancer with 16 per cent 5-year cures. Taylor and Greeley[4] reported 15.2 per cent salvage rate or 5-year cures for their series of 138 malignant cases. They reported the cure rate for the pseudomucinous adenocarcinoma as 20 per cent and for the serous adenocarcinoma as 14.3 per cent. They believe that the most important factors affecting the prognosis for ovarian cancer are the gross stage of the disease at the time of operation and the histologic grade of the tumor. The first factor, that of gross involvement, is elementary and generally agreed upon by most surgeons.

Grading is of comparatively little value because of the wide variations in the histologic pattern of ovarian carcinomas. This can be readily understood when one considers that there is no field in gynecology in which the prognosis is more uncertain than in ovarian tumors. This is true both clinically and pathologically. Roughly speaking, tumors of low malignancy survive longer.

The following case reports will emphasize some of the difficulties encountered in the diagnosis and treatment of ovarian cancer.

Illustrative Cases

Case 1.—Mrs. H. T., a white woman, aged 27 years, was first seen on June 16, 1939 with a low abdominal mass, backache, loss of weight, diarrhea, and pain in the left lower quadrant. She stated that her symptoms had been developing over the past year but had become particularly bad during the past 6 months. She had mumps, diphtheria, measles and scarlet fever during her childhood. Catamenia began at 16 years, recurred every 28 days, and lasted 7 days. Periods had been entirely regular except for 3 months following radiation therapy with intra-uterine radium which she had received 3 years before for uterine hemorrhage. At this time the diagnosis of a left ovarian cyst was made. Eight years before she had had a dilatation and curettage for uterine bleeding. She had never been pregnant. There was no history of any venereal infection, although this was later denied by her husband and father.

Exploratory laparotomy on June 17, 1939 revealed an extensive pelvic malignancy with omental cake and intestinal implants. A nodule removed from the omentum and an intestinal implant revealed papillary adenocarcinoma probably ovarian in origin.

Following a course of roentgen therapy with very satisfactory improvement, she was reöperated upon on May 11, 1940, 11 months after the initial operation, and the uterus, both tubes, ovaries, appendix, and a portion of the omentum were removed. Microscopic sections from the left adnexal mass revealed papillary cystadenocarcinoma. On May 18, 1940 she was readmitted to the hospital for a secondary abdominal closure following an evisceration at home on the morning of the same day.

On June 13, 1940 she was reöperated upon for intestinal obstruction. At this operation, in addition to freeing the obstruction, the remaining portion of the omentum which contained 2 nodules was removed. Microscopic sections from these nodules revealed many leukocytes, plasma cells, and a number of Langhans-Schuppel giant cells. Numerous plaques of typical foam cells were noted. A single acinus lined by flattened, somewhat irregular epithelium was evidently an indication of malignancy, corresponding to the previous reports.

Comment on Case 1.—This case shows the value of combined preöperative radiation and surgery in certain cases of ovarian malignancy with omental cake and intestinal implants. A review of her history also shows the fallacy in using intrauterine radiation for controlling adolescent bleeding when a small ovarian cyst is palpable.

A third lesson was learned from this case when evisceration followed the operation. Although the X-ray therapy had been given many months before, it was undoubtedly a factor in this development.

Even though this patient still has cancer, as evidenced by the findings in the sections removed at operation for intestinal obstruction, she is still living and well 7 years after beginning treatment.

Case 2.—Mrs. M. N., aged 50 years, was admitted to the hospital for continuous vaginal bleeding. Her periods, which had been irregular for the past 3 years, stopped in May 1938, reappeared December 1938, and continued intermittently until April 24, 1939, when a diagnostic curettage was performed.

Bleeding began again following the dilatation and curettage, and continued to the present admission.

Patient was advised that unless the bleeding stopped following the dilatation and curettage in April 1939, she should be operated upon. Combined abdominopelvic examination revealed a small retroverted fixed uterus and a tender left adnexal mass. Speculum examination revealed a bloody drainage from the cervical canal.

On October 25, 1939, a bilateral salpingo-oöphorectomy, hysterectomy and appendectomy was perforemed. Microscopic sections from the adnexal mass which resembled a combination cyst revealed a highly vascular and cellular structure of the epithelial type with a glandular arrangement in some areas. The process was diagnosed as a papillary cystadenocarcinoma arising in a papillary cyst.

Follow-up X-ray therapy was advised and refused. On August 12, 1942, 2 years and 10 months later, the patient returned complaining of enlargement of glands on the left side of her neck, loss of weight, weakness, and loss of appetite. Examination revealed discreetly enlarged lymph glands just above the left clavicle, palpable left axillary glands, and a hard, palpable, epigastric mass.

Biopsy of a cervical gland showed metastatic adenocarcinoma. The patient was referred for X-ray therapy. She died from metastatic cancer 3 years and 6 months after operation.

Comment on Case 2.—The clue in the diagnosis of this case was the continued bleeding after the diagnostic curettage, which was negative for uterine pathology. Had the patient been operated upon at this time, her chances for complete cure would have been much better. Ovarian malignancy must be suspected in any patient over 50 years of age with irregular bleeding even with negative uterine pathology. Roentgen therapy, which was advised but refused in this case until generalized metastases had occurred, might have been of value in prolonging the patient's life beyond the comfortable 3 years which she experienced. It is of some interest that this patient's mother and a sister died from cancer.

Case 3.—Miss J. H., a white woman, aged 43 years, was admitted to the hospital on May 26, 1941, for study and diagnosis. Her complaints consisted of low backache, lumbar discomfort radiating to the left flank and groin, and low abdominal discomfort with marked constipation. The above symptoms were present for the preceding 2 months. A recent medical survey was entirely negative for physical findings.

Menses began at 11 years, recurred every 28 days, and lasted 5 to 7 days. The last menstrual period had begun on April 13, 1941 and lasted 5 days.

X-ray examination on April 29, 1941 was entirely negative for the chest, lungs, pleura, heart and great vessels. Examination of the lumbar spine, pelvis and sacrum showed the presence of only 4 lumbar vertebrae, with the fifth being sacralized and forming part of the sacrum. Examination of the colon showed the descending sigmoid portions to be very spastic. Reëxamination of the colon on May 5, 1941 was entirely negative.

Combined abdominopelvic examination under gas anesthesia on May 29, 1941 revealed the uterus to be small, in good position, and movable without pain. There was a tumor mass apparently arising from the right adnexal region lying behind the uterus. The left adnexa was negative.

On May 30, 1941 a large right ovarian cyst, the right tube, and the appendix were removed. The cyst was removed intact without spill. Paraffin sections from the cyst showed a papillary pseudomucinous cystadenoma with malignant changes. Following the operation, the patient was referred to the Warwick Clinic for roentgen therapy.

On July 26, 1941, while under treatment, a roentgenogram of the chest revealed an extensive pleural effusion in the base of the left pleural cavity with several metastatic nodules in the parenchyma of the right lung. The patient died several months later.

Comment on Case 3.—This case shows quite clearly the unreliability of the grading of ovarian tumors in prognosticating the outcome. The pathologist reported this tumor as a very slow-growing, grade 1 neoplasm, and gave an excellent prognosis. Contrary to this, the patient developed pulmonary metastases within 2 months after operation while being treated with X-rays and died within the year. Furthermore, it teaches one not to depend too much on roentgen therapy to cure the patient.

Knowing that ovarian cancer can occur at any age and that its onset is insidious, all ovarian tumors should be viewed with suspicion. Early recognition through careful history-taking and careful physical examination is possible, and operation on suspected ovarian tumors should never be delayed.

At the operating table any questionable ovarian tumor should be subjected to fresh frozen section technic and the diagnosis established immediately. All too often an innocent-appearing papillary cystadenoma is removed and forgotten until the patient returns a year or two later with inoperable carcinoma.

The proper treatment of malignant ovarian epithelial growths is accomplished by means of radical surgery, with removal of both tubes, both ovaries, the uterus, and the cervix. This is particularly necessary because of the large percentage of these tumors that are bilateral and the possibility of metastases being present in the uterus and cervix.

If a mistake has been made and an ovary left in, it is better to operate again than to risk X-ray treatment alone.

In those cases with extensive pelvic involvement, omental cake and intestinal implants, careful roentgen therapy will frequently make them operable. As a working basis, it must be remembered that X-ray treatment will prolong life but will not cure the patient and should not be used to replace radical surgery.

The key to the improvement in salvage rates for ovarian cancer is, of course, early diagnosis. The encouragement of periodic pelvic examination would be a step in this direction and the proper use of the peritoneoscope as recommended by Meigs[6] should also be of some value.

In regard to preventive treatment, there is none unless we adopt Crossen's recommendation[1] to remove all involuting ovaries whenever the abdomen is opened under circumstances which permit of such removal. This idea is well worth considering.

SUMMARY

A brief discussion of papillary cystadenocarcinoma of the ovary, together with the treatment and results in 3 typical cases, has been presented.

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THE EXPERT MEDICAL WITNESS*

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When he first goes to Court as an expert witness the average doctor feels as strange as does the average lawyer on his first visit to the operating room. The formalities and restrictions of the Court make the doctor feel uncomfortable and out of place. He swears to tell the whole truth and nothing but the truth, but he very soon discovers that this is often a figure of speech and that he is allowed to tell only that portion of the truth that is convenient to the attorneys involved in the case. His testimony consists in answers to questions, and his efforts to elaborate can be, and often are, futile. He is usually allowed to quote the patient about the history of the injury, and to state the results of his physical examination, and his opinion as to the patient's present and future disabilities, if any.

If the doctor keeps in mind that the Judge, the lawyers, and the jury are all laymen to him, and that they all have only a superficial understanding of the technicalities of the medical profession, and that his is the role of instructor, he will cease to be embarrassed by Court formalities. He must, of course, be truthful and honest in his testimony and believe in what he says. He should limit his answers to the scope of the questions. He should avoid technical terms as much as possible and, when it is necessary to use them, he should immediately explain them in the simplest language. It is often convenient to use a blackboard and chalk to explain a particular point. The doctor need not be an artist to do this. A line here and one there may make an answer clear which would otherwise be misunderstood. A jury follows a visual demonstration with attention and appreciation, and the demonstration is usually followed by an increased regard for the expert's subsequent testimony. Dr. D. Percy Hickling, who appeared in Court more frequently than others of his generation, used to say that he took the jury in his lap and told them a one-syllable story.

It is difficult to maintain neutrality, and the tendency is for the expert to color testimony in favor of the side which employs him. He is tempted to conceal facts which would give aid and comfort to the opposing side, and to stress facts which would be of advantage to his employer. Only super experts can be nonpartisan. The wise medical expert, then, will refuse to testify in any case in which he does not thoroughly believe all the testimony that he is expected to give. The time is coming when expert witnesses will be appointed by the Courts and paid by them. Then, they will regain prestige which has been lost in recent years by diametrically opposed testimony offered by eminent men who were employed on opposite sides of the same cases.

In order to qualify as an expert medical witness, the doctor must convince the Court that he has had experience with or special study of the type of injuries under discussion. Since the courses leading to the degree of Doctor of Medicine include practically all subjects which require medical testimony, it is not difficult for the average doctor to qualify as to preparation by study, and postgraduate hospital work should have supplied the required experience.

The expert witness should dress quietly, should talk loudly enough to be understood, should be respectful to the Court and to the attorneys present, and should impress the jury that he is modest but sure of his facts. He is first interrogated by the lawyer who employed him. Previous to the trial, a careful lawyer will go over the case with the doctor and will inform himself as to what testimony the doctor will give. Clever questioning on the part of the attorney will give emphasis to the facts which are favorable to his side of the case. The medical witness is assured of kindly and considerate treatment at the hands of his attorney. If the doctor has confined himself to the facts and has shown himself to be well informed and logical, the opposing side will ask but few questions, and the doctor's time on the stand will not be unduly prolonged, nor will it be unpleasant. If, however, the doctor has testified beyond his immediate field of knowledge, he will have an uncomfortable time trying to explain something he does not know all about. There is no more impressive way to demonstrate frankness and honesty than to answer, "I do not know," when such is the case. On the other hand, it is extremely dangerous for the witness to guess about a matter on which he is not fully informed. If the guess can be proved to be wrong, the entire testimony of the witness loses its force and may be discounted. An example of this is the circumstance of a general surgeon who reads and interprets an X-ray film on the stand. This is not the general surgeon's work. In the hospital, he depends upon the roentgenologist to point out abnormalities to him. He has not had the experience necessary to interpret all that the film shows, and he should realize that he will be followed on the stand by a roentgenologist who may demonstrate conditions which were hidden from the inexperienced eye, and that the jury will notice the discrepancy. It is much safer for the medical expert to refuse to identify pathology on an X-ray film on the ground that he is not an expert in that particular field. The wise opposing lawyer will ask the well prepared medical witness very few questions. In Chicago, some years ago, an eminent, popular doctor had given testimony which was very damaging to the other side. When the opposing lawyer, who realized that he could not soften his testimony, confronted the doctor, he addressed him as follows:

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* Read before the Society, May 8, 1946.

Q. Doctor, did you attend Mr. Armour's father?
A. Yes, sir, I did.
Q. Where is he now?
A. He is dead.
Q. Did you attend Marshall Field's father?
A. Yes, I did.
Q. Where is he now?
A. He is dead.
Lawyer: That's all.

The doctor had no opportunity to explain that these were two very old men who had died of natural causes ten years before. The effect on the jury was detrimental to the medical witness.

Some lawyers are rude, rough, and threatening to the medical witnesses on the opposing side. They raise their voices, point their fingers to emphasize their remarks and to "play act" for the jury's benefit. The medical witness should never lose his temper, but should become more calm and quiet as the lawyer becomes more vehement. The jury's sense of fair play benefits the witness. Sooner or later, the lawyer may mispronounce a medical term. This affords an opportunity for the doctor to say to the jury that there is no such word as the lawyer just used. The lawyer becomes nettled; the jury, amused.

After each question is asked by either lawyer, the medical witness should allow time for objection, and, if there is one, he should not attempt to answer until he is instructed to do so by the Judge. When his testimony is finished, he should leave the Courtroom at once, and he should not appear to be interested in the outcome of the case.

The record of surgical examination of a person who has been injured and who is seeking financial redress should include the name, address, age, and occupation, and give a brief history of previous injuries, operations, and past illnesses; give the date of injury, time of day, geographic location of the accident; state whether the patient was taken to a hospital, which one, for how long, and if not, whether he was taken home, and how—did he walk, take a streetcar, taxicab etc.; state when he employed a doctor and whom he employed; note how long he was in bed and confined at home, when he returned to work; give a list of his injuries; relate whether X-ray films were taken and by whom; investigate X-ray reports; and list symptoms which are complained of at the present time.

The general characteristics, such as apparent age, height, weight, evidence of pain, limping, cerebration, etc. should be described. The blood pressure, pulse rate, and heart examinations should be made. Urinalysis and other laboratory procedures will suggest themselves and should be done only if circumstances warrant. It is not necsssary to record examinations of the head, neck, chest, abdomen, etc. if the only injury claimed is to the hand or to the foot. Only essential facts should be recorded and voluminosity avoided.

The extremities in a case of injury should be compared and abnormalities in anatomy and physiology noted. Scars should be described accurately as to location, direction, width and depth. Swelling of the extremities should cause investigation of the heart, kidneys and blood. Accurate measurements should be made when extremities are compared.

The system of the body involved in the accident should be described in detail and all important symptoms and signs recorded.

The next paragraph should be called "Discussion," and in it briefly the high spots of the history, physical and emotional examination reviewed, and their bearing on the conclusions given. The seriousness of permanent ugly scars and deformities with no interference with function depends upon the age, occupation, and economic status of the patient. They are not so important in the adult day-laborer or washerwoman as they are to the adolescents, society women, and salesmen, in whom they may cause an inferiority complex which would be detrimental to social advancement and to earning capacity.

Injuries which interfere permanently with function are more important to those who live by manual labor than to those who employ servants, ride in automobiles, whose occupations are sedentary, or whose age is great. A wealthy old woman, for instance, can get along with a fractured hip with nonunion much better than a younger person whose livelihood depends upon physical activity.

Under "Conclusion," one's opinion as to whether the patient presents any objective evidence of injury may be stated, and if so, what; whether it will be permanent, and, if not, what will be the probable duration. The subjective symptoms in the light of general knowledge of the patient should be assessed, and the report closed with the prognosis. Reports for corporations are usually made in triplicate; two go to the company, which sends one copy to the patient's lawyer, and the third is retained by the examiner for future reference. It must be kept in mind that the opposing lawyer gets one copy of the report and unnecessary statements should not be made, such as, "The patient was evidently putting on an act, and lied frequently during the examination," or, "The patient was unusually coöperative and honest, and if he said he had a headache, I am sure he had." Ordinary tact should restrain introduction of material which would cause embarrassment. Each examination is a potential court case, and nothing should be included that one is not ready to defend under oath.

Not long ago a surgeon was testifying for a corporation and, while admitting that the plaintiff could not use her arm and that the arm was anesthetic and that the disability was more than a year in duration, stated that all its functions would resume in time and that improvement would begin after the conclusion of the law case. The opposing lawyer asked him to explain to the jury why the paralysis and anesthesia had lasted for a whole year. The surgeon replied that the continued disability was due to an oversolicitous lawyer and an overconscientious doctor. The jury found for the corporation. The neurosis was continued by constant rehearsal of symptoms with a neurotic patient.

A general surgeon was testifying as an expert in an orthopedic case. He had been preceded on the stand by an eminent orthopedic surgeon, whose opinion differed from that of the witness. On cross-examination the opposing lawyer asked him if he was an orthopedic specialist. The answer was, "No." "Ah!" said the lawyer, "You are just a general surgeon!" "No," said the witness. "What are you, then?" asked the lawyer. "I am a general surgeon, and not just an orthopedic specialist," said the witness.

It is unwise for the medical witness to admit familiarity with any textbook unless he is truly familiar with it. If he does not admit familiarity (which might be interpreted as basis for his opinion), the book cannot be used to refute his testimony. In case of well known textbooks which the doctor must have read from time to time, the medical witness can call attention to the fact that most textbooks are obsolete in ten years. If it is shown that the edition presented is less than ten years old, the doctor may point out to the jury that medicine and surgery are too vast for any one man to have an authoritative opinion on all the matter contained in the book and that, therefore, the author might be mistaken in some of the statements printed therein.

The medical witness should never appear on a contingent fee basis. This will unduly influence his testimony. Arrangements for his fee had best be made in writing by the attorney who employs him. The expert witness should include in his fee the cost of the examination of the patient, the preparation of the case, and the actual time he is on the stand. Usually the lawyer will conserve the doctor's time by phoning him one-half hour before he knows he will testify, and, of course, the doctor will promptly respond.

An ordinary medical witness in Civil Court is one who has seen an accident, or who has participated in the examination and/or the treatment of the patient. He can be subpoenaed and brought to Court to tell what he knows about the case. He is allowed the few dollars' fee which any other ordinary witness receives. He receives no remuneration for loss of time. and must, in many jurisdictions. answer questions which require special knowledge and experience, i.e., expert testimony. in the interests of justice and without an extra fee. The stock in trade of a doctor is the facts he has memorized plus his experience and judgment. He uses them to make his living, and he should be allowed to use them to his own advantage, and not be forced to give them away. The expert witness is one who usually has not treated the patient and has not witnessed the accident but who has been hired to make an examination by one side or the other for the purpose of reporting what the facts are. Many times his written report of his examination decides whether a settlement shall be made or the case go to trial.

Some attorneys insist that the expert's examination be done in the presence of the claimant's doctor. Any information the claimant's doctor has to give can be obtained over the telephone, and his mere presence is usually a waste of time. It has been my experience to have a room assigned to me in the doctor's office and the examination is done while he treats his patients in the other room. In the interests of manpower and rubber, these lawyers should allow the plaintiff to call at the expert's office. To insist upon the presence of the claimant's doctor is an implied reflection upon the motives or honesty of the examiner without effect on either.

Experience soon allows the examiner to distinguish between the really injured patient and the malingerer, or the neurotic. In traumatic neurosis the patient must have been of a neurotic makeup before the accident, and his symptoms are in inverse proportion to the severity of the accident. I think the term "traumatic neurosis" is unfortunate. It implies that the neurosis is the direct result of the injury, when, as a matter of fact, it occurs only in those whose previous history shows marked neurotic tendencies, and it does not occur in normal people. For instance, a woman in middle life may have suffered for months or years from menopausal neurosis. She is injured in a streetcar accident. The conductor may have been rude to her immediately afterward. Her feelings have been lacerated. She is indignant at the Company which is represented by the conductor. Further, there is a possibility of recovering substantial damages, depending upon the extent of her disability. The injury supplies a reason for her to obtain the sympathy and attention of her friends and relatives. She has good reason then to concentrate on her injuries, and when she does so, they become exaggerated. She employs a lawyer in order to obtain justice. The repetition of her symptoms in preparation for the trial fixes their importance more firmly in her mind. The symptoms found on examination by the medical expert witness have little or no organic basis. The expert, therefore, testifies before the jury that she is suffering from traumatic neurosis. The jury's sympathies are aroused, and they give her damages because the defense has admitted that her neurosis was caused by trauma. As a matter of fact, this woman had a neurosis for years. The accident merely distracted her attention from the symptoms which were present and concentrated it on her injuries. She is not a malingerer. She actually considers her symptoms are real, but she deceives herself, her friends, and often the jury. History shows that most of these cases recover from the injuries sooner or later after the litigation has been settled either for or against the patient, but the old menopausal neurosis will continue until the patient has become adjusted to the fact that youth has passed. She continues to worry her husband and her friends by her complaints and unreasonable reactions to life. Therefore, when testifying, I think the term traumatic neurosis should be discarded and the witness might say that the patient has a neurotic background, and that the accident has furnished a means of securing the sympathy and concern of other people. It can usually be demonstrated that the symptoms complained of do not follow anatomic or physiologic signposts.

The story of the draftee who was faking bad eyesight comes to mind. The Draft Board oculist asked him to read the letters on the chart. "What chart, Doctor?" asked the draftee, "I do not see any chart!" "Well," said the doctor, "if your eyesight is that bad, you cannot enter the Army." That evening the draftee was at the movies, and when the lights came up he looked at the man sitting next to him. It was the Draft oculist. There was mutual recognition. "Excuse me, sir," said the quick-thinking draftee, "but does this bus stop at Chevy Chase?" Limping patients sometimes forget to limp; disabled arms sometimes help to remove waists and shirts; injured spines sometimes perform all normal motions without restriction or discomfort.

Never prescribe or give any advice to claimants. I once examined a nervous, hysterical woman for a streetcar company. She had recently moved to wartime Washington and had tried, without success, to obtain medical services during the previous three days. She had not slept during this time. Her nervous condition was really pathetic. As she was leaving my office, I handed her a sample box containing two nembutal capsules and told her to take one that night to get some sleep. One week later the company read me a letter from her lawyer threatening suit because I had poisoned her and doped her so that she could not remember clearly the circumstances of the accident. This cured me from offering any advice whatever.

Ulcers of the leg found sometime after an accident often are accompanied by varicose veins and show pigmentation from previous ulcers. They may have preëxisted. Syphilis may be present. These conditions do not relieve the defendants of responsibility, but they are mitigating circumstances. In affections of special organs like eyes, ears, bladder, etc., I usually request an examination by a specialist, and his report is attached to mine.

Incontinence of urine in the female is often accompanied by torn and relaxed outlet muscles with prolapse and cystocele following childbirth and chargeable to that and not to the accident.

Muscle spasm near the spine denotes irritation in this vicinity. It is quite painful and is nature's effort to secure rest for the part until the cycle of the inflammatory process is complete. After injury, muscle spasm should not persist for more than a few weeks, yet we have testimony that muscle spasm is present two years after an injury. This is a strain on the credulity of the informed. Of course, inflammatory or neoplastic processes may be present in or near the spine and these can prolong muscle spasm, but usually there is no evidence on X-ray films or by other examination of such a condition. Such testimony is pure imagination.

Scoliosis of the spine is sometimes claimed to be the result of an accident. While this is not impossible, the accident must have been a severe one indeed to bring about this condition. Scoliosis is usually developed in the young and is due to lack of ligamentous tonicity which encourages poor posture and consequent deformity. It results, also, from prolonged drainage of empyema and other diseases which exist for a long time. I do not know of any ordinary injury which can be blamed for the condition, yet it is claimed by litigants and expert witnesses from time to time.

Traumatic appendicitis is thought to be possible by some and denied by others. I, personally, think it is possible. I can imagine a blow on a full caecum, forcing some of its contents into the appendix to an extent which interferes with emptying the appendix, with consequent circulatory embarrassment. I can also imagine an appendix being in juxtaposition with the bony pelvis and being traumatized by external force.

Once while I was examining a claimant I was presented with X-ray evidence of multiple fractures which I checked with the patient's deformity and found that they coincided. After the case was settled out of Court and the patient had collected damages, it came to my knowledge that the patient had been injured five years before the claimed accident and the connivances of a crooked doctor and the same kind of lawyer had "sold" the old injuries to the corporation which employed me to make the examination. I now never fail to inquire about previous injuries the claimant may have sustained.

Subjective symptoms like pain in the lower back are difficult to estimate. X-ray examination should be done when this symptom is present and even when this is negative, the possibilities of nerve injury, tumors, dislocated intervertebral discs, etc., are always present. A good deal can be learned by observing the patient closely as he walks, stands, and sits for evidences of pain or awkwardness. The patient who smiles and laughs readily is usually in no particular pain.

Injury to the brain or its coverings offers serious problems and makes prognosis difficult. Great stress is usually laid upon the fact that the roentgenogram shows a fracture of the skull. I maintain that a fractured skull is no more serious than a fractured great toe, if there is no injury to the underlying structures. Skulls frequently show fractures without injury to the underlying structures, and fatal brain injury may occur without a fracture of the skull. Contusion and laceration of the brain are serious indeed, even after immediate recovery because sequelae such as epilepsy, brain abscess, brain cyst, etc., have been known to occur many years after the accident and have been attributed to this injury. I do not use the term "concussion of the brain" on the witness stand. The term is too elastic, too difficult to define, and the explanation of "molecular rearrangement" is academic and unintelligible to the jury. The jury understands "shaking up of the brain," "bruising of the brain," "laceration of the brain," etc., and they can understand the effects of hemorrhage and scarification and adhesions of the cerebral tissues.

Inguinal hernia which has existed for years is often "sold" to corporations after accidents.

Its location prevents observation by others previous to the accident, and claims are often made that the accident caused it. When an inguinal hernia develops in an individual, we know that he carried a potential hernia since he was a fetus, and that it is only necessary to exert a particular force to the hernial area to cause "the protrusion of a viscus through the wall which normally contains it," this constituting a hernia. A description of the accident by the patient will suggest to the examiner whether the patient's body could have been in a position to exert this peculiar force, and the symptoms immediately following the accident would be important for or against the assumption. Hernial swelling caused by trauma is usually immediately painful, shocking, and disabling. If operation reveals adhesions and a thickened sac, the hernia has existed for years.

Cancer frequently follows repeated or continued trauma or irritation and is probably not caused by one blow, yet we see cancer of a previously, apparently normal breast following an accident which included trauma to the breast. In cases of this kind there probably was a small, circumscribed, unnoticed cancer present previous to the accident whose growth was accelerated by aggravation and releasing encapsulated cancer cells. It is difficult to reconcile bone cancer or sarcoma with an accident, because surgeons drill holes in bones, use chisel and hammer on them, and otherwise insult them without resulting neoplasms. Since the etiology of cancer is unknown, the opinion of an expert witness that it was caused by one blow is unprovable and becomes "post hoc, ergo propter hoc" reasoning.

Uterine bleeding and irregularity of menses are frequently complained of following accident. This is not usually caused by uterine trauma because the uterus is normally very well protected by the bones of the pelvis. It is possible for trauma to prematurely rupture a Graafian follicle and thus upset the menstrual cycle temporarily and cause bleeding and irregularity. No one will deny that shock and trauma can cause miscarriage. There seems to be no doubt that trauma can exaggerate an already displaced uterus by causing strain on already overstretched ligaments.

Examples have been presented to show that there are many controversial questions which can arise after a person has been injured. These call for the exercise of mature judgment based upon knowledge and experience, and sometimes give opportunity for honest difference of opinion between expert medical witnesses.

Claimants coming to the attention of the surgical expert witness may usually be classed in three groups, malingerers, neurotics, and organically injured persons. Experience makes the differentiation usually easy. Many seriously injured cases do not reach Court because corporations find it cheaper to settle outside of Court if liability is established. Likewise, minor injuries seldom reach Court because the awarding of a few hundred dollars, even in undeserving cases, is much cheaper for a corporation than expenses involved in a trial. This leaves the run-of-the-mill cases which do not differ much from each other and make pleasant, interesting work for the surgical expert witness, if he likes it.

I have advanced some of my own ideas based on an experience of about forty years, during which time I have been an expert medical witness now and then. Any resemblance of these ideas with those of medical or surgical authorities, living or dead, is purely coincidental.

The ideal expert medical witness should combine the wisdom, knowledge, and savoir faire of a Wallace Yater, a Charlie White, and an Earl Clark. You can understand, then, that there "ain't no such animal." But this fact need not discourage anybody who aspires to do this work. A physician who attends the Medical Society, reads his journals regularly, and who has had average experience, can be a creditable expert. He should remember that when testifying he may sometimes be mistaken, but he should never be in doubt.

President's Page

WELCOME TO THE ASSEMBLY

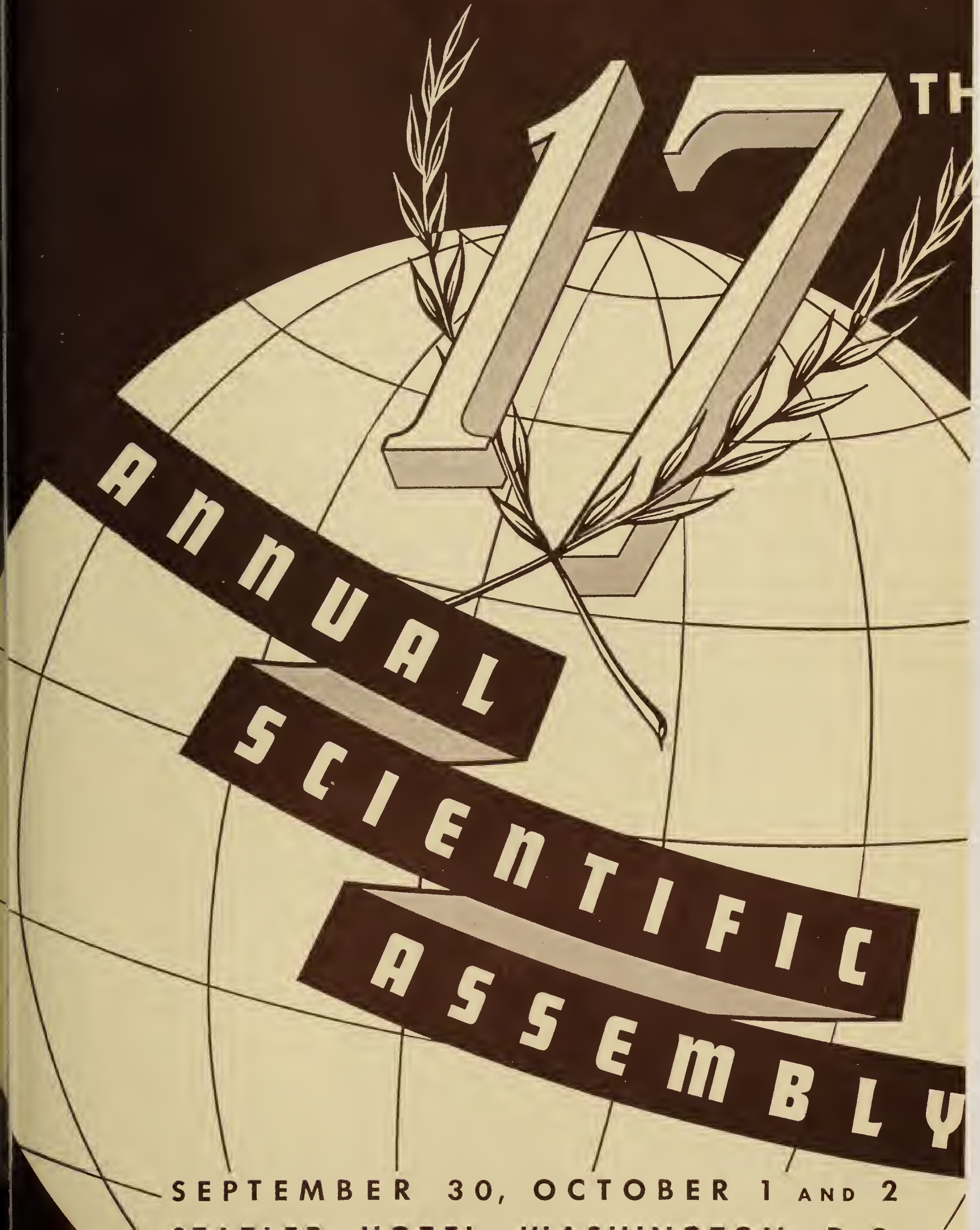
At this time we are looking forward to the resumption of our practice of holding an ANNUAL SCIENTIFIC ASSEMBLY. The scene will be new in that we will hold the meeting at the Statler Hotel. The facilities there should make it possible to present the ASSEMBLY under ideal conditions.

The scientific program promises to be the finest we have ever offered. It will take in all of the outstanding new contributions in the field of medicine. The atomic bomb and its biological effects, tropical diseases which menace us, chemotherapy, cancer research, and challenging social experiments will make for an unusually well rounded program.

The high quality and significance of the program material and the participation of physicians from the important medical centers lead me to invite most enthusiastically all of our members and their professional friends, here and in adjoining states, to enjoy what the Society's committees are planning to make the finest ASSEMBLY the Medical Society of the District of Columbia has underwritten.

William P Herbst Jr

THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA



17TH ANNUAL SCIENTIFIC ASSEMBLY

SEPTEMBER 30, OCTOBER 1 AND 2

"Medicine Forward!"

Medicine is today on the threshold of an era of great promise. The theme "Medicine Forward!" is therefore particularly appropriate.

Although the medical profession is primarily interested in what lies ahead, it can with profit review medical advances made during the war years. Some of these lay only in the field of military medicine, but most of them will benefit all mankind. As is always the case, experience alone will demonstrate the true value of knowledge which has been gained about new drugs and therapeutic procedures.

As the scientific program reveals, emphasis has been placed upon advances in all branches of medical science. There will be great interest, of course, in atomic energy and its relation to medicine. Panel discussions on such vitally important subjects as cancer, poliomyelitis, and thromboembolism should not only prove interesting but inspiring as well. Despite the progress yet to be made in the treatment of these conditions, there have been significant advances.

Due to the fact that the ASSEMBLY is to be held for the first time at the Hotel Statler, Washington, those attending should note carefully the places where the meetings are held and the exhibits are displayed. The Statler was designed with conventions especially in mind, so participating physicians and their guests should find it most convenient. Every effort has been made to confine all of the activities in connection with the ASSEMBLY to the Statler.

Social functions abandoned during the war are being resumed. Of course, a majority of the members of the Society will turn out for the luncheon on the first day, it being given for the membership. Others, however, are most welcome to attend. Tickets can be obtained by them at the registration desk. Then there will be the public meeting which, because of its nature, should attract a large audience. The subject to be discussed is "Atomic Energy and Your Future Health." Women physicians will hold a banquet on the second evening, and the ASSEMBLY will come to a close with a dinner in the Presidential Ballroom for physicians, their wives and guests. There are some details in connection with these events that were not available at the time the MEDICAL ANNALS went to press and will be announced a little later.

Let me urge all members seeking information about the most recent medical advances and who find pleasure in fraternizing with their fellow practitioners to be on hand during the ASSEMBLY. *Set aside September 30, October 1 and 2* for this purpose. You will be well rewarded.

W. Ross Morris

GENERAL CHAIRMAN,
COMMITTEE ON ARRANGEMENTS

Photo by U. S. Department of the Interior, Courtesy National Park Service

17th Annual Scientific Assembly

SCIENTIFIC PROGRAM

All Sessions in the Presidential Ballroom, Statler Hotel

MONDAY, SEPTEMBER 30—MORNING SESSION

POSTWAR PROBLEMS IN CIVILIAN PRACTICE

10:00 Late Manifestations of Tropical Diseases

Captain Omar J. Brown, M.C., U.S.N.
Chief of Medicine, Camp LeJeune, North Carolina

10:30 Virus Hepatitis

Joseph J. Stokes, Jr., M.D.
Professor of Pediatrics, University of Pennsylvania

11:00 Recess

11:15 Experiences in the Santo Tomas Prison Camp

Lt. Colonel Emmett Pearson, M.C., A.U.S. (Retired)
Springfield, Illinois

11:45 Recess for Luncheon

MONDAY, SEPTEMBR 30—AFTERNOON SESSION

LESSONS FROM WORLD WAR II

2:00 Removal of Foreign Bodies from the Heart

Dwight E. Harken, M.D.
Massachusetts Memorial Hospital, Boston

2:25 Coronary Heart Disease in World War II

Wallace M. Yater, M.D.
Consultant in Pathology, Army Medical Museum

2:50 Newer Methods in the Treatment of Thyroid Disease

Frank A. Lahey, M.D.
Boston

3:15 Recess

3:30–4:30 Panel Discussion on Recent Advances in Cancer

Fred R. Sanderson, M.D., Moderator
Professor of Surgery, Georgetown University School of Medicine

Research—**R. R. Spencer, M.D.**
Chief, National Cancer Institute, Bethesda, Md.

Radiation Therapy—**Edgar M. McPeak, M.D.**
Washington

Urology—**William P. Herbst, Jr., M.D.**
Professor of Urology, Georgetown University School of Medicine

Surgery of the Head and Neck—**Calvin P. Klopp, M.D.**
Director of Warwick Memorial Cancer Clinic, Washington

General Surgery—**H. H. Kerr, M.D.**
Clinical Professor of Surgery, George Washington University School of Medicine

Thoracic Surgery—**Brian Blades, M.D.**
Professor of Surgery, George Washington University School of Medicine

TUESDAY, OCTOBER 1—MORNING SESSION

CONTROL OF VENEREAL DISEASE

10:00 Venereal Disease Control in Norway
Thorstein Guthe, M.D.
Assistant to the Surgeon General of Norway

10:25 National Control of Venereal Disease
J. R. Heller, Jr., M.D.
Medical Director, U. S. Public Health Service

Discussion—**S. Ross Taggart, M.D.**
Director, Venereal Disease Department, District Health Department

11:00 Recess

11:15 The Modern Treatment of Syphilis
Frank W. Reynolds, M.D.
Instructor of Medicine, Johns Hopkins University School of Medicine

11:45 Recess for Luncheon.

TUESDAY, OCTOBER 1—AFTERNOON SESSION

ADVANCES IN THE USE OF ANTIBIOTICS

2:00 Advances in Penicillin Therapy
Captain Monroe Romansky, M.C., A.U.S.
Medical Officer in Charge of Antibiotic Research, Walter Reed General Hospital

2:25 Streptomycin—Its Present Uses
John A. Kolmer, M.D.
Professor of Medicine, Temple University School of Medicine

2:50 Intestinal Chemotherapeusis
Moses Paulson, M.D.
Assistant Professor of Medicine, Johns Hopkins University School of Medicine

3:15 Recess

3:30–4:30 Panel Discussion on Thromboembolism
Hugh H. Hussey, Jr., M.D., Moderator
Associate Clinical Professor of Medicine, Georgetown University School of Medicine

Laboratory Determinations—**Andrew G. Prandoni, M.D.**
Formerly Chief of Peripheral Vascular Clinic, Walter Reed General Hospital

Diagnosis—**Thomas F. Keliher, M.D.**
Associate Clinical Professor of Medicine, Georgetown University School of Medicine

Blood Coagulability—**Kaare K. Nygaard, M.D.**
White Plains, New York. Formerly Assistant Surgeon, University Clinic, Oslo, Norway

X-Ray Manifestations—**George M. Wyatt, M.D.**
Washington

Surgical Treatment—**J. Ross Veal, M.D.**
Associate Professor of Surgery, Georgetown University School of Medicine

New George Washington University Hospital

WEDNESDAY, OCTOBER 2—MORNING SESSION

New Georgetown University Hospital

10:00 THE USE OF FOLIC ACID IN THE TREATMENT OF BLOOD DYSCRASIAS

Charles A. Doan, M.D.
Professor of Medicine, Ohio State University School of Medicine

10:25 THE PHYSICAL ASPECTS OF THE ATOMIC BOMB

Captain George Lyon, M.C., U.S.N.R.
Safety Advisor of Joint Task Force Number One in the "Operation Crossroads"

11:00 RECESS

11:20 THE PSYCHOSOMATIC APPROACH TO PEPTIC ULCER

Edward Weiss, M.D.
Professor of Clinical Medicine, Temple University School of Medicine, Philadelphia

11:45 RECESS FOR LUNCHEON

WEDNESDAY, OCTOBER 2—AFTERNOON SESSION

2:00 TRANSTHORACIC VAGOTOMY IN PEPTIC ULCER

Francis P. Moore, M.D.
Department of Surgery, Massachusetts General Hospital, Boston

2:25 INTESTINAL ULCERATIVE DISEASE

J. Arnold Bargen, M.D.
Mayo Clinic

2:55 X-RAY DIAGNOSIS OF INTESTINAL ULCERATIVE DISEASE

Aubrey O. Hampton, M.D.
Chief, Radiology Department, Garfield Memorial Hospital

3:15 RECESS

3:30–4:30 PANEL DISCUSSION ON POLIOMYELITIS

Milton C. Cobey, M.D., Moderator

Charles Armstrong, M.D.
Chief of the Division of Infectious Diseases, National Institute of Health

Robert Bennett, M.D.
Surgeon in Charge of Physiotherapy, Georgia Warm Springs Foundation

William P. Green, M.D.
Orthopedist-in-Charge of Infantile Paralysis Section, Children's Hospital, Boston

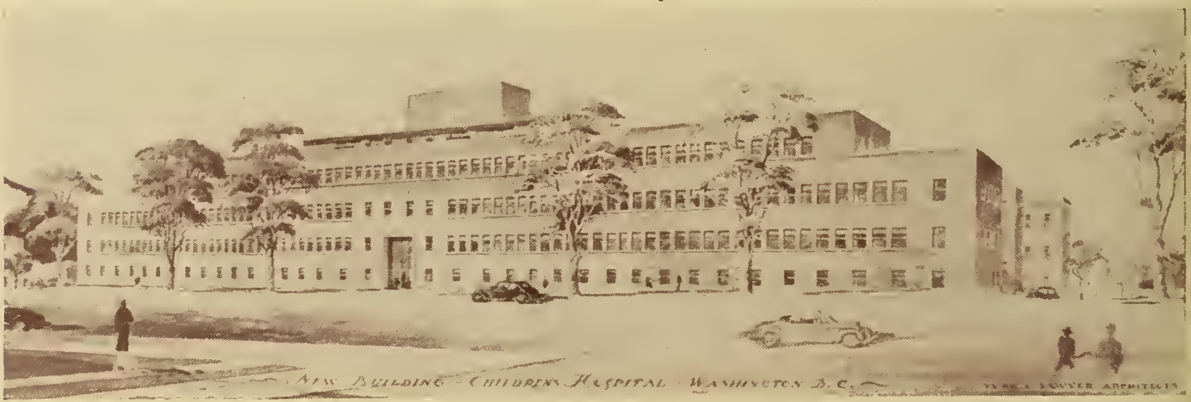
Joseph S. Wall, M.D.
Chief of Medical Staff, Children's Hospital, Washington

Doctors Hospital Addition

Scientific Exhibit

The Scientific Exhibit will be on display in the South American Room at the Statler Hotel. Motion pictures will be shown in the Private Dining Room No. 1 which adjoins the South American Room.

Subjects	*Sponsors*
ALIMENTARY TRACT OUTPOUCHINGS	Walter H. Gerwig, Jr., M.D.
ALLERGY—POLLENS THAT PRODUCE SEASONAL HAYFEVER IN THE DISTRICT OF COLUMBIA	Robert Sterling McGrath, M.D.
CONTINUOUS CAUDAL ANESTHESIA IN OBSTETRICS	George J. Ellis, M.D., L. V. Dill, M.D., and Joseph B. Sheffery, M.D., Department of Obstetrics, Geogetown University School of Medicine
ARMY INSTITUTE OF PATHOLOGY	Army Institute of Pathology, Washington, D. C.
CONGENITAL SINGLE CORONARY ARTERY IN MAN	Joseph T. Roberts, M.D., and Samuel D. Loube, M.D.
AMERICAN RED CROSS BLOOD DONOR SERVICE	District of Columbia Chapter, American Red Cross
BENIGN AND MALIGNANT LESIONS OF BONE	George M. Wyatt, M.D., and W. S. Randall, M.D.
AVAILABLE SERVICES IN A CANCER CLINIC	The Warwick Memorial Clinic, Garfield Memorial Hospital
TECHNICS IN CANCER RESEARCH	National Cancer Institute, Bethesda, Md.
CULDOSCOPY: A NEW DIAGNOSTIC APPROACH IN GYNECOLOGY	Aaron H. Gerber, M.D.
CYSTOURETHROGRAPHY—USE OF A NEW MEDIA	Frederick O. Coe, M.D., Department of Radiology, Georgetown University Hospital
ELECTROENCEPHALOGRAPHIC STUDIES IN ELECTROSHOCK THERAPY	St. Elizabeths Hospital; Winfred Overholser, M.D., Superintendent
ELECTROHYSTEROGRAPHY	L. V. Dill, M.D.; Robert Maiden, Radio Engineer; J. J. Mundell, M.D.; United States Navy and Georgetown University School of Medicine
GALL STONES	J. Russell Verbrycke, Jr., M.D.
THE COMPARATIVE MORPHOLOGY OF THE LATERAL GENICULATE BODY	Othmar K. Solnitzky, M.D., Department of Anatomy, Georgetown University School of Medicine
STUDIES ON THE SMALL BLOOD VESSELS OF THE HEART AND PERIPHERAL NERVES	Joseph T. Roberts, M.D.
HEPARIN IN THE TREATMENT OF THROMBOEMBOLIC DISEASE	Leo Loewe, M.D., Edward Hirsch, M.D., David M. Grayzel, M.D., Bernard S. Epstein, M.D., and Harold B. Eiber, M.D.
HORMONES IN SEXUAL DIFFERENTIATION	Charles F. Morgan, M.D.
COMPARISON OF GLOBIN INSULIN AND PROTAMINE ZINC INSULIN IN EQUAL DOSES	Joseph T. Roberts, M.D., and Wallace M. Yater, M.D.
STERNAL MARROW STUDIES	Pearl B. Holly, M.D.
ACTIVITIES OF THE BUREAU OF MENTAL HYGIENE, DISTRICT OF COLUMBIA HEALTH DEPARTMENT	Bureau of Mental Hygiene, District of Columbia Health Department
NURSERIES DESIGNED FOR MODERN MATERNITY	George Washington University School of Medicine
ORTHOPEDIC RECONSTRCTION PROCEDURES	William J. Tobin, M.D., Orthopedic Department, Georgetown University School of Medicine
ACTIVITIES OF THE DEPARTMENTS OF PEDIATRICS, SURGERY, AND SOCIAL SERVICE, CHILDREN'S HOSPITAL	Children's Hospital, Washington, D. C.
RESULTS OF PSYCHOTHERAPY	Benjamin Karpman, M.D.
THE MENACE OF THE RAT	American Medical Association
PRACTICAL ASPECTS OF THE RH FACTOR	Oscar B. Hunter, M.D., and Oscar B. Hunter, Jr., M.D.
PROTEIN HYDROLYSATE IN SURGERY	Charles S. White. M.D., and J. J. Weinstein, M.D.
SURGERY OF HYPERTENSION	J. Ross Veal, M.D., and Hugh H. Hussey, M.D.
THE FURTHERANCE OF THE ASSOCIATION'S PROGRAM TO X-RAY GENERAL HOSPITAL ADMISSIONS	District of Columbia Tuberculosis Association
ULTRAVIOLET BLOOD IRRADIATION	G. J. P. Barger, M.D., Physical Therapy Section, Georgetown University Hospital
VENEREAL DISEASE CONTROL CONTACT EDUCATION, CONTACT TRACING	Bureau of Venereal Diseases, District of Columbia Health Department; S. Ross Taggart, M.D., Director


NEW BUILDING CHILDREN'S HOSPITAL WASHINGTON D. C.

New Building, Children's Hospital

Technical Exhibit

The Technical Exhibit will be on display in the Congressional Room, which is immediately off the upper lobby. It will be necessary for those who wish to attend scientific sessions to register in the foyer before entering the Congressional Room. Thirty-eight firms are participating in the Exhibit. They are as follows:

Ayerst, McKenna & Harrison, Limited	(Booth 1)
Beuchler's	(Booths 28 and 29)
Bilhuber-Knoll Corporation	(Booth 15)
Borden Company	(Booth 36)
Brand, Paul L.	(Booth 3)
Burroughs, Wellcome & Co. (U.S.A.) Inc.	(Booth 39)
Camel Cigarettes	(Booths 19 and 20)
Cameron Surgical Specialties Company	(Booth 10)
Ciba Pharmaceutical Company	(Booth 14)
Davies-Rose and Company	(Booth 9)
Doak Company	(Booth 12)
Doho Chemical Corporation	(Booth 23)
Fleet, C. B., Company	(Booth 16)
Gibson Company	(Booth 2)
Hansen's, Chr., Laboratory	(Booth 17)
Haskell, Charles C., & Company	(Booth 31)
Kloman Instrument Company	(Booth 37)
Lederle Laboratories	(Booth 26)
Liebel-Flarsheim Company	(Booth 41)
Lilly, Eli, & Company	(Booth 40)
Maxwell & Tennyson	(Booth 35)
Mead Johnson & Company	(Booth 30)
Merrill, William S., Company	(Booth 7)
Parke, Davis & Company	(Booth 38)
Peoples Drug Stores	(Booth 8)
Philip Morris & Company	(Booth 34)
Reed & Carnrick	(Booth 33)
Sanborn Company	(Booth 27)
Sandoz Chemical Works	(Booth 4)
Saunders, W. B., & Company	(Booth 24)
Searle, G. D., & Company	(Booth 21)
Sharpe & Dohme	(Booth 13)
Smith, Kline & French Laboratories	(Booth 32)
Spencer Support Shop	(Booth 11)
U. S. Vitamin Company	(Booth 18)
Walker Vitamin Products	(Booth 22)
Washington Institute of Medicine	(Booth 6)
White Laboratories	(Booth 25)

Hedrich-Blessing Studio

Congressional Room, Hotel Statler

War Souvenirs Exhibit

In the past years it has been the custom of the Assembly to present a special exhibit which is timely and of unusual interest. A War Souvenirs Exhibit has been selected this year.

Many of the Society members who have served in the armed forces have choice items and collections. The all-veteran War Souvenirs Committee has therefore limited its selection to material from ex-service physicians of the Society. It will be one of the finest exhibits of this type shown in the city.

There will be other items besides medical souvenirs on display which will appeal to the laity as well as to physicians and those in allied fields.

The exhibit will be set up in the foyer immediately adjacent to the South American Room where the Scientific Exhibit will be held. It will be open daily from 10:00 a.m. to 5:00 p.m. Everyone should plan to visit it.

Synopsis of Program

(All meetings at the Statler Hotel unless otherwise indicated)

MONDAY, SEPTEMBER 30, 1946

9:00 A.M.: Registration
10:00 A.M.–11:45 A.M.: Scientific Program
12:15 P.M.–1:30 P.M.: Medical Society Luncheon, Presidential Ballroom
Speaker: Daniel C. Fahey, Chief Planner, Civil Affairs Division, War Department
Subject: American Occupation—The Destiny of Two Hundred Million People
2:00 P.M.–4:30 P.M.: Scientific Program
8:00 P.M.: **SPECIAL.** Scientific and War Souvenirs Exhibits, South American Room and Foyer, open to physicians, their families and friends.

TUESDAY, OCTOBER 1, 1946

10:00 A.M.–11:45 A.M.: Scientific Program
12:15 A.M.–1:30 P.M.: George Washington University Medical Society Luncheon, Presidential Ballroom
Speaker to be announced.
2:00 P.M.–4:30 P.M.: Scientific Program
6:00 P.M.: Women's Medical Society Dinner, Pan American Room, Mayflower Hotel
8:15 P.M.: Public Meeting, Presidential Ballroom
Speaker: Captain George M. Lyon, M.C., U.S.N.R., Safety Advisor of Joint Task Force No. 1 in the "Operation Crossroads"
Subject: "Atomic Energy and Your Future Health"

WEDNESDAY, OCTOBER 2, 1946

10:00 A.M.–11:45 A.M.: Scientific Program
12:00 noon–1:30 P.M.: Georgetown University Medical Alumni Association Luncheon, Presidential Ballroom
Speaker: Rear Admiral William S. Parsons, U.S.N., Deputy Commander for Technical Direction, Joint Task Force No. 1, "Operation Crossroads"
2:00 P.M.–4:30 P.M.: Scientific Program
7:30 P.M.: Annual Dinner, Presidential Ballroom
Speaker: Mr. Justice Robert H. Jackson, Associate Justice Supreme Court of the United States
Subject: "Medical Aspects of War Crimes Trial"

Registration

HOTEL STATLER

As usual arrangements have been made to register members of the Society before the opening of the Assembly. It is strongly urged that those who find it convenient to do so, register at the Society's offices between 9:00 a.m. and 5:00 p.m. on Friday, September 27, and between 9:00 a.m. and 1 p.m. on Saturday, September 28. Visiting physicians, medical officers from the various branches of the armed forces, and Society members not previously registered may do so at the Hotel Statler beginning 9:00 a.m., Monday, September 30. Special provisions have been made for registering dentists, residents, interns, nurses, pharmacists, technicians, medical students and others who wish to attend the Assembly. Badges and official programs are obtainable at the registration desk. No one will be admitted to the scientific sessions without a badge.

In order to attend the Society luncheon on Monday, September 30, it is necessary to register before 1:00 P.M., Saturday, September 28. There will be no charge to members of the Society. Out-of-town physicians and other non-members of the Society, except military personnel, will be required to pay a registration fee of $5.00, which includes the luncheon. Physicians in military service and other non-members wishing to attend only the luncheon may purchase a ticket for $3.00. Arrangements to attend the luncheon sponsored by the George Washington University Medical Society and the Georgetown University Medical Alumni Association can be made at the registration desk.

Editorials

FIRST POSTWAR ASSEMBLY

The 17th ANNUAL SCIENTIFIC ASSEMBLY, to be held at the Statler Hotel, Washington, on September 30, October 1 and 2, is the first postwar ASSEMBLY. All signs point to a memorable meeting. Not in years has the Committee on Arrangements and its subcommittees labored so enthusiastically in preparation for Washington's outstanding medical event. No effort is being spared to surpass, if possible, the high standards set at previous meetings.

Reports from over the country indicate that there is greater interest in medical meetings than in several years. The Committee on Arrangements, therefore, anticipates the largest registration in the ASSEMBLY's history. As usual, there will be a number of visiting physicians. Their Washington colleagues will, of course, give them a warm welcome and show by their regular attendance at scientific sessions how highly they regard their ASSEMBLY.

A special effort is going to be made again this year to register as many members as possible. This is one of the tasks to which the Subcommittee on Attendance will dedicate its most earnest efforts. It is the belief of the Chairman of the Subcommittee that the percentage of members who attend can be raised from the maximum of 65 per cent to at least 80 per cent. The Subcommittee requests every member who attends the ASSEMBLY to register. Some have ignored this important obligation in past years.

Appropriately, the theme of this year's ASSEMBLY is "Medicine Forward!" Recent developments in the Nation's Capital give every promise that Washington is to become a great medical center. Not only are new hospital plants in the process of erection, but decided progress is being made by our medical educational institutions. In line with the theme chosen, the ASSEMBLY, too, is growing and expanding into a very useful instrument for making better doctors.

ORGANIZED MEDICINE*

Medical societies were started primarily for the exchange of scientific information and to improve the doctors' knowledge of methods of diagnosis and treatment. This purpose still exists and our good reputation is based largely on our acquisitive interest in scientific facts so that we may apply these facts to the diagnosis and treatment of the sick.

Over 100 years ago (February 1845) a resolution was introduced in the Medical Society of the State of New York by Dr. Nathan S. Davis, which was the first step in the formation of our present national organization. The preamble to this resolution read as follows:

> *Whereas*, It is believed that a National Convention would be conducive to the elevation of the standard of medical education in the United States.

This shows that thought was being given to the elevation of professional standards even at that early date. This interest has continued and in addition many other interests have developed, all of these having to do with rendering a better medical service to the public.

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* This is the seventh in a series of guest editorials by distinguished physicians and laymen. Others to follow will deal with the scientific, social and economic aspects of medicine.

Looking over the proceedings of our national organization, we find that its efforts have at times been directed toward the eradication of quackery and unethical practices. At other times attempts have been made to protect the public from fraud through the indiscriminate sale of nostrums and to educate the lay person in methods of obtaining and maintaining good health. In these and many other matters, the constituent societies have each played their part.

At the present time various social and economic changes are taking place all over the world and they are having a pronounced effect on certain aspects of the practice of medicine. Some of these changes are good and should be encouraged; others are poor and should be opposed. There is only one way to act in these cases and that is by free discussion in order to arrive at the proper conclusions, and having arrived at them to present a united front either for or against the proposed change. Very often this free discussion will bring about new ideas which may be integrated into the proposed change.

When we are sure that our cause is a just one, we need not fear criticism and we should not fear to reply to such criticism, provided the source is worthy of attention.

In order to do all this a certain amount of sacrifice on the part of the individual physician is necessary. He will have to be regular in attendance at county and state society meetings. He will have to read the organizational sections of his journals as well as the scientific ones. He may be called on for committee work or other chores that are time-consuming and that may appear thankless at the time they are taking place.

We have often seen how effective an *organized* minority can be. This is due to the fact that they are *organized*, and united, and all have the same objective. In addition most organized minority groups are aggressive and are heard because one of their objectives in being organized is to give publicity to their cause. If the majority were as well organized and as aggressive, then the minority would soon be evaluated at its proper worth.

Clear thinking and a united front are the two things that will preserve for us and for our patients the high standards of medical care that we have gradually developed in this country since the eventful days of the 18th century when we became a free nation. If we can improve these standards let us do so, but never let us be a party to anything that would tend to lower the standards.

George F. Lull, M.D.
Secretary and General Manager,
American Medical Association

PENICILLIN FOR EMPYEMA

It is a matter of common clinical experience that the incidence of pleural empyema has decreased considerably in the past 5 years. Beyond doubt this improvement is a tribute to the efficiency with which the various sulfonamides used during this period for the treatment of pneumonia have curtailed all complications of this disease, empyema included. On the other hand, the use of sulfonamides for the treatment of established empyema has been mainly unavailing, so that the cure of empyema usually required surgery.

Recently the experience with penicillin in the treatment of empyema has been reviewed and summarized,[1] and it is obvious that the management of the condition is changing. It is apparent from the information at hand that about 50 per cent of cases of empyema can be cured without resorting to operation. The details of the technic of treatment are by no means completely settled. It is agreed, however, that the mainstay of therapy is frequent, thorough aspiration of the pus followed by intrapleural instillation of penicillin. At first, aspiration should be done every 12 to 24 hours. When evidences of toxicity of the disease subside, as they usually will within a few days, the interval between aspirations can be lengthened to 48 hours. Probably it is best to irrigate the pleural space with saline before penicillin is instilled, especially if the pus is thick. The intrapleural dose of penicillin recommended is 50,000 to 100,000 units. The larger dose offers the advantage that it will usually provide adequate levels of penicillin in the blood for at least 24 hours. This fact is of some importance because in many instances of empyema, residual pulmonary or other infection also requires treatment. For this purpose, of course, systemic therapy with penicillin by another route can also be employed.

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[1] Brown, B., Ory, E. M., Meads, M., and Finland, M.: Ann. Int. Med., 1946, **24**, 343.

In cases in which favorable results are obtained by this method, symptoms of toxicity rapidly subside, the pleural fluid becomes sterile early, and the pus thins and diminishes steadily. Treatment must be continued until all evidences of the disease have disappeared or until it is decided that surgical treatment should be substituted. Decision to advise operation in any case must be based on the findings and course of events in the case. Apparently it is safe to continue conservative therapy indefinitely as long as the results appear favorable.

The effects of conservative treatment in cases of putrid empyema deserve special mention. Like bronchopleural fistula, this condition formerly was considered to be an acute surgical emergency. The use of penicillin intrapleurally, however, permits delay, with the attendant advantage that the patient is considerably less toxic and the surgical risk correspondingly less. Indeed, it is not improbable that a cure may be effected without operation in some cases.

It should be understood that a larger experience with the treatment under discussion must be obtained before standardization of technic can be expected. Until this is forthcoming, keen appraisal of each case during its entire course is mandatory. It may be dangerous to think in terms of the avoidance of operative treatment. It is to be hoped, of course, that operations will be unnecessary in many cases, but perfect teamwork of the internist and the thoracic surgeon is indispensable in the management of empyema. In those cases in which surgical treatment is employed, the use of penicillin nevertheless improves the situation. The risk of operation is reduced and the period of postoperative illness and incapacitation is shortened.

H. H. H.

FAREWELL TO INTELLIGENTSIA

Becoming aware of our learning omissions
We sought out a meeting of famous physicians
Reviewing the heart and its ramifications
In terms like "auricular" plus "fibrillations."
Their lingo, admittedly over our head,
Had echoes, somehow, of the quick and the dead;
But we, being neither, soon scented the need
To find erudition more nearly our speed.

We trekked to a forum a few blocks away
Where science, atomic, was having its day.
A physicist, noted, with cranium high,
Was fashioning "fission" in verbiage dry.
We tried to keep up but were soon out of sight
And, finding the exit, slipped into the night.

A social work session next loomed into view;
"Let's listen," we thought, "for a minute or two,"
But they were discussing some tests "psychometric"
And "orientation" with trimmings eclectic.

* * *

So, thanking our friends who may rate us a pundit,
We can't take the credit; we herewith refund it.
Those technical soirees are not for the laity—
We wound up the night in a seat at the Gaiety!

Ray H. Everett

In and Out of Focus

BY THE OBSERVER

'Failure Is Unthinkable"

San Francisco is an ideal city for a medical meeting. It is not only a picturesque, stimulating place to visit, but it has ample first-class hotel and restaurant facilities. What is equally important, people of this metropolis are exceedingly friendly. In consequence, the visitor soon feels very much at home. No better choice could, therefore, have been made for the annual meeting of the American Medical Association held there in July. The weather fortunately was made-to-order, the program excellent, which made the occasion from any point of view most satisfactory. On its part, the California Medical Association outdid itself in making the whole affair one long to be remembered.

Except for a brief visit to the exhibits, and participation in a conference on public relations, your Observer confined himself to attending sessions of the House of Delegates. Much of the discussion in the House this year centered around legislation and prepaid medicine.

In your Observer's opinion, the most significant and certainly the most effective address was made by Dr. Roger I. Lee of Boston, the AMA's retiring President. Resembling in appearance his good friend, Winston Churchill, he is undoubtedly one of the ablest medical leaders in this country. Devoting himself to the present medical situation, he expressed deep concern because "certain fundamental changes are taking place."

"During the war the American people gladly submitted to substantial regimentation," Dr. Lee said. "It was the view of the American people that this was the price of winning the war. We were minded to sacrifice temporarily some of our precious freedom to achieve a larger freedom. But a spector of doubt is beginning to appear. Are we in fact, not in theory, going to regain our old freedom? In my belief the medical profession has suffered severely in its loss of freedom. I think we must all agree that it is likely that from now on the constituted governmental authority will inject itself to an increasing degree in medical affairs. In some instances the governmental interest may be benevolent at least in intent. Your Association supported the principle involved in the Hill-Burton bill*. But if the execution of the Hill-Burton bill depends not on need but on political pressure, then the medical profession has exchanged a part of its birthright of freedom for a mess of pottage.

"Again the United States government is manifesting a great interest in science and there is likelihood of a very large expenditure of governmental funds for science. Your Association has teamed up with other scientific organizations in favoring the development of a National Science Foundation. But while the intent of such legislation is wholly benevolent, the administration and execution of such legislation may be of a different order. Science is a coy and jealous mistress, and her enduring charms are often not purchasable for a fixed price and do not always go to the highest bidder. Then too the practice of medicine is an applied science. While the art of medicine with a dash of science is very old, medical science is new. Like it or not there is an aristocracy of science which on occasion may be a bit intolerant.

"I have cited these two illustrations because I'm sure the intent is benevolent. But I believe that dangers to the profession lurk there just the same as in the more obvious attempts of governmental intervention, as in the case of the Wagner-Murray-Dingell bill."

Having stressed the dangers inherent in the present situation, Dr. Lee pleaded for wider participation of physicians in public affairs. He said:

"As citizens of a great nation, we doctors have privileges and obligations. Most of those privileges and obligations do not come into the realm of our medical organizations. Some of our disappeared freedom affects us as citizens rather than as doctors. But it is the same freedom. It is, I think, nothing short of a grievous calamity that medicine is such a hard taskmaster that few physicians can combine the practice of medicine and public office. Certainly the physician knows poverty and disease, and also wealth and disease. He knows suffering and sin. He knows people. I believe he is entitled to a seat and a voice at the council table and not in the next room as a possible expert or specialist. I believe the local community, the state, the nation and any congress of nations would benefit by his advice on public matters. Today he is almost automatically excluded, and thereby the world suffers. Furthermore for its own interests, which are so peculiarly altruistic, the medical profession needs a voice at the council table. No other group is more unselfish and altruistic in its traditions and aims than medical men. And yet in a recent unofficial and voluntary conference on world affairs no doctor of medicine was present in the throng of lawyers, clergymen, editors, social scientists, physical scientists, commentators, and others.

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*The bill authorizes $75,000,000 per year for 5 years for hospital construction and $3,000,000 for state-conducted surveys of needs. Division of the Federal funds is based upon a population and per capita income formula.

"Why this exclusion from public and world affairs? I have suggested the trite and time worn explanation that the doctor is occupied and engrossed in purely professional matters. But certainly doctors have attained standing in poetry, music, and the creative arts. They can hardly be accused of a constricted horizon. Somehow for the benefit of the general public and of the world and for the benefit of the medical profession itself this situation ought to be remedied.

"I am far from suggesting that this House of Delegates take any action or adopt any resolution to this end. I do believe, however, that individually and collectively the medical profession should seek to achieve those benefits which can be derived only from a wider participation of doctors in public and world affairs.

"It is the younger members of the medical profession who will be most concerned with the changing order of medical practice. It is the younger doctors who will be involved in the development of the provisions of the Hill-Burton bill and of a National Science Foundation. Likewise it is the younger doctors who will bear most of the responsibility of working out many of the details of medically-controlled prepayment medical care plans. Therefore once again I bespeak for them a large share in the affairs of the county or district medical societies, state medical societies and the American Medical Association.

"Out of the welter of discussions, of trial and error under the leadership of the Council on Medical Service and Public Relations, a medically-controlled nationwide plan for prepaid medical care is emerging. The development of this plan will require medical statesmanship. It must succeed. Failure is unthinkable. But while I hope the younger members of the profession will direct and operate this plan, all of us, young and old, must pull a powerful laboring oar."

The AMA can ill afford in these critical times to dispense with the services of Dr. Lee. It is to be hoped that although he is no longer the Association's President, top AMA officials will seek his wise counsel frequently.

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More Government Medicine

Before reading an article on some controversial medical issue, your Observer usually turns to the concluding paragraphs. If they interest him, he is inclined to read the material in its entirety. He is doubly interested when, as happened recently, the writer states, "It has been my one desire to keep emotion entirely out of any part of this discourse." And so it came about that he read with care an article entitled, "Federal Medicine and the Doctor," by Dr. George A. Schenewerk, which appeared in the July number of the *Dallas* (Texas) *Medical Journal.*

Taking a broad view of his subject, Dr. Schenewerk observes, "The type of world in which we live, and particularly the type of our national government, will exert a determining influence on medicine in the years ahead." Two diametrically opposed systems of government, he says, are seeking world leadership. "Our economic society will sooner or later become organized somewhere between these two extremes; however, if great social changes come too quickly, they produce unnecessary hardship and confusion. There are those who believe improvement can come only by the state assuming more and more power, but there are those who believe as did Thomas Jefferson, '. . . to restrain men from injuring one another, otherwise, leave them free in the pursuit of their own business.'

"Which system will dominate the world? Will more power be delegated to the State in America? Will it remain as it now is, or will there be a gradual diminishing of the activities of Government? The answers to these questions will determine what type of world we live in and particularly what type of national government we will live under. This will also exert a strong determining influence on the type of medicine and the method of practice we will have.

"In recent years, there has been a tendency toward a more bureaucratic form of government in the United States. This tendency has been accelerated in the past decade. Whether this situation will continue or reverse its direction will, of course, depend upon the people of the United States. From all indications, however, it appears that the present trend will continue; if so, what is the present status of medicine, and what will it be in the near future?

"At the present time much of medicine is already 'socialized' or under governmental planning and control."

Dr. Schenewerk then describes the various forms of Government medicine, beginning with towns and municipalities upon whom devolve the responsibility of conducting departments of health, operating hospitals, and so on. He outlines the health programs of the United States Health Service, Army, Navy, Merchant Marine, and the Veterans Administration.

With respect to the latter, he points out, "If at a later date this service should be extended to cover dependents, it would bring approximately 76,000,000 persons (over one half of the entire population) under this branch of governmental-controlled medicine. This merits very careful and vigilant consideration by the medical profession."

Directing his attention to labor, Dr. Schenewerk says, "Probably the most powerful group in the Nation today, and the one which will exert an influence on the practice of medicine along with every other endeavor in the future, is that of labor. Whoever controls industry in an industrial state has power, and industry is now controlled by labor." Four out of five persons are now wage-earners or salaried employees depending upon the labor market for their jobs. The result is "a good deal of insecurity." Various insurance measures covering unemployment, disability, old age, death, hospital and sickness have been adopted, yet the wage earner "has had a severe struggle to improve his lot, often placing his interests in the hands of those whose character is somewhat reproachful."

"On the whole," Dr. Schenewerk believes, "labor leaders have conducted themselves well in the interests of those they serve and do not merit the many innuendoes cast upon them by their antagonists. Unions, for various and sundry reasons, are said to be 'leftist' or 'rightist.' In the C.I.O. the Leftists include Bridges' longshoremen, Curran's maritime workers, Mike Quill's transport workers, Fitzgerald's electrical workers, Grant Oak's farm-equipment workers, and the Federal Workers of America. The Rightist unions include Johnny Green's shipbuilders, Philip Murray's steel workers, R. J. Thomas' automobile workers, and Emil Rieve's textile workers. Sidney Hillman's clothing workers usually tip the scale to the left. Philip Murray, President of the C.I.O., is not a European Radical and fundamentally believes in the American system although he backs the C.I.O. program for Government aid in social amelioration. He also believes in the Wagner Act and in the uses of the C.I.O. Political Action Committee. He maintains that he believes absolutely in competitive capitalism and expects to obtain labor improvement only by means of bargaining with presentation of facts. Whatever the character of the individual labor leader may be, it is certainly too much power to bestow on one individual, to allow him the authority to plunge our cities into darkness, paralyze the wheels of industry, create untold suffering and cause financial losses that can never be computed. All fair-minded citizens believe in the dignity of labor and the right of labor to organize and bargain collectively, but most of those on the sidelines in the controversies between management and labor believe that grievances should be settled before a board having competent jurisdiction and backed up by proper rules, regulations and procedures, and that strikes should be considered as wasteful to the body politic as a whole and discontinued. If it is an accepted fact that henceforth labor will have much more power and prestige it behooves us to view labor as it is rather than as it has frequently been pictured."

Because labor makes up a large segment of our population—$37\frac{1}{2}$ million of the non-farm families—Dr. Schenewerk is satisfied that "The aspirations and goals of labor will have an effect on medicine. Labor wants more medical care for its members than it has heretofore obtained, and medicine is desirous that all of the benefits of modern medicine be made available to labor. The discrepancy enters as to the method of administration. Labor supports the compulsory health bill as presented by Senators Wagner and Murray and Representative Dingell; the medical profession is firmly against this socialistic endeavor. The medical profession maintains that if the chief hindrance to utilization of the medical care which is available is an economic problem, then that problem can better be handled by private agencies than governmental agencies. In other words, organized medicine says government has advanced far enough in the field of control over medicine; labor says it needs to go further. Since organized medicine objects to the compulsory health insurance plan what does it offer in its place?"

Dr. Schenewerk agrees with many another physician that the AMA has been slow in coming forward with a solution, but he agrees that the Association has now made a good beginning. He is, of course, opposed to compulsory health insurance, and believes that the voluntary type can succeed.

"In retrospect, then," he says, "it will be seen that much of medicine is already 'socialized' or under governmental control; it will probably go further. The question now, then, is how much further?" The answer, he says, "will depend upon the type of government under which we will live in the future and the wisdom, character, energy, and aggressive activity of the younger members of the profession. The older members have left a noble heritage; it is the duty of the young and strong to carry on the good fight so that the people of America will continue to have more and better medical service with each succeeding year regardless of the ebb and flow of the fortunes of the various political factions."

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Medical Center Authorized

It would now appear a certainty that the hospital center long sought by three Washington hospitals, Emergency, Garfield, and Episcopal, will become a reality. For Congress in late July passed the hospital construction bill which has been under consideration for the past three years. However, before its enactment, it was amended with the result that the section providing for grants to hospitals other than the three participating in the medical center, was eliminated. In other words, non-participating hospitals will not receive funds as provided in the original bill to improve and replace outmoded facilities. Surprisingly, the Congress did not trim the $35,000,000 authorization. The original bill contemplated an expenditure of $15,000,000 to $20,000,000 for the center, the remainder to be used for grants to other Washington hospitals.

Deploring the action of the Congress in giving "the District a badly mutilated hospital construction bill," the *Washington Post* for July 30 observed that "Improvements to the neighborhood hospitals of this community are urgently needed and must be authorized when Congress reconvenes if we are to have a rounded program for the modernization of our medical facilities.

> "Authorization of the hospital center is of itself a real gain, of course. The preparation of plans can begin at once. These should be ready for presentation to the new Congress as soon as it meets, so that an appropriation bill can be passed and actual construction started with the least possible delay. Under the terms of the authorization measure now approved by Congress and awaiting the President's signature, the three participating hospitals would contribute their present land and buildings, the Federal Works Agency would put up the cash necessary for construction of the new center, and the District of Columbia would be required to reimburse the FWA for 30 per cent of its outlay 'when and in such manner as the Congress may determine.'
>
> "Obviously this presents a fiscal problem for the District. It is a problem which Congress alone can solve. And one indispensable step toward solution of it is an enlargement of the Federal contribution to the District's revenue in accordance with the Overton-O'Mahoney formula. Having recognized the inescapable need for better hospitals in the Federal City, Congress can scarcely dodge the need for enabling the District to meet the obligations thrust upon it. Thus, quite apart from the practical benefits to the health of this community conferred by the hospital construction bill, there is significant collateral value in its dramatization of our financial crisis. Congress has been very handsome in unbalancing the District budget. It can get the reimbursement it expects only if it is equally handsome in providing the means to bring the budget back into balance."

President Truman had not yet signed the hospital center bill when this was written, but it was fully expected that he would do so.

On March 7, 1945, the Medical Society went on record favoring this legislation in principle, providing that "all non-profit voluntary hospitals rendering services to the indigent and the near-indigent in the District of Columbia be given equal opportunity to participate and are assured equal representation in the corporate body."

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Life Span Lengthens "In 1944, for the first time in our history, the average length of life (expectation of life at birth) of the American people, including military personnel within the country, exceeds 65 years." Almost 16 years greater than at the turn of the century, the *Statistical Bulletin* of the Metropolitan Life Insurance Company for May describes it as a "truly remarkable gain." The *Bulletin* observes that an individual now age 20 has, on the average, as many years of life ahead of him as a newborn child in 1900. Perhaps a more striking observation is that only three quarters of the babies attained the age of 25 at the beginning of the century, compared to the same number who reach the age of 57 today.

As might be expected, the average length of life of white females in 1944 exceeded that of white males, it being 68.95. Males trailed the "weaker sex" by nearly 5 years, 63.55 years. They reached their highest level in 1942, the above figure for 1944 being slightly lower. This was due to the high mortality from accidents among men in military services. The gain in the average span of life of white females since 1900 was 18 years, that of white males in the same period being 15⅓ years.

While the situation for colored persons improved correspondingly, it was still at the level for that of white persons in 1919-1921. Expectation of life at birth among colored males was 55.30 years, and among colored females 58.99 years. Gains made in this group since 1900 were 22¾ years and 24 years, respectively.

"It is significant," the *Bulletin* states, "that the improvement in expectation of life so far this century has not been restricted to the early years of life, but has extended into the higher ages as well." As an illustration, at the age of 40 the population as a whole had a life expectancy in 1944 of 31.63 years, practically 3⅓ years more than at the turn of the century.

Under current mortality conditions, it is pointed out, a half century of life remains, on the average, for white females age 22, white males age 17, colored females age 13, and colored males age 10. Corresponding ages at which quarter of a century of life remains, on the average, are white females 50, white males 46, colored females 45, and colored males 41.

The *Bulletin* concludes: "That our country was able to reach a peak in longevity in the midst of war, reflects the effectiveness of American medical and public health services and the high standard of life of our people. To have passed the 65-year mark in average length of life at a time when a large part of our medical personnel was drawn from civilian life, is good assurance that the American people will find it possible in peacetime to reach the next goal, 70 years, and within a fairly short time."

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Words Without End The recent departure of his faithful and efficient secretary during the past four years was a severe loss to your Observer. But with matrimony in prospect, his feelings were properly of little moment. Before she took leave, he reminded her there was a little matter to be taken care of. Files in the storeroom on the third floor of the Society's building were bulging with records which somehow must be disposed of. These she was more familiar with than anyone else. To which she responded that she had begun her services with the Society by cleaning the "attic" and she might just as well finish the same way. Your Observer volunteered to assist with the task, and his offer was promptly accepted. It was a novel experience for him as he had usually delegated such tasks to others, but it proved to be worthwhile from many points of view.

For one thing, he learned how many worthless office records are saved to no good purpose. The files were choked with letters which should have been destroyed years before. There were voluminous documents devoted to subjects no longer, and perhaps never, important. There were queries, complaints, questionnaires, minutes, and what not, covering a period of more than a decade. Most of this material had no value, historical or otherwise. That which did, of course, was carefully saved.

What impressed your Observer most of all was a drawer in a filing cabinet jam-packed with material on medical economics. There were hundreds of letters, pamphlets, bulletins, reports, and addresses on this subject. These were kept for their historical value, or until such time as they could be examined in more detail.

Your Observer reflected how many millions of words had been written on medical economics with little effect so far as the public is concerned. Medical men, it would appear, had been equally resistant. For the subject is still as timely today as it was back in the early 1930's. Which goes to prove the vast amount of effort necessary before any subject as complex as medical economics takes root in the public consciousness.

But such reflections aside, old files might be described as words without end, gathering dust.

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The Public Will Decide In the heat generated by controversial medical issues, doctors are apt to lose sight of a very important fact. Decision as to the future of medical practice is not entirely in their hands.

Mr. John Hunton, Executive Secretary of the California Medical Association, writing in the *Wisconsin Medical Journal* for June, has something to say on this subject. California, he says, has been confronted with various forms of compulsory health insurance since 1917. Only last year, 28 years later, the controversy in that state reached its peak. The California medical profession had the battle of its life defeating compulsory health insurance legislation backed by Governor Warren.

The big question in California still remains, Mr. Hunton observes, whether there shall be compulsory or voluntary sickness insurance. By voluntary insurance, he means all voluntary forms—commercial insurance, California Physicians' Service, closed panel groups, "any expression of the voluntary method of prepayment of unpredictable costs." The position taken by his organization is that all types of voluntary systems should compete with each other, and "may the best man win."

> "The ultimate thought, of course," Mr. Hunton says, "is that the public is and will continue to be the best judge of what it wants. We may sit in our offices and attempt to take a vicarious pulse on public opinion but in the long run the public itself will supply the answer. Suffice it to say that there has been a public demand for some form of prepayment of medical and hospital costs over a long period of years; the public will eventually select its own expression of prepayment, whether it be a non-profit medical plan, a commercial insurance plan, or a government-sponsored and government-controlled compulsory plan."

Until the public makes up its mind, it is his opinion that medical organizations are obligated to keep legislators informed of their views. He especially urges that an adequate information office be maintained in state capitals and in Washington, D. C.

To this, your Observer would add that the medical profession's influence with the public in the coming months will depend more on what it does than on what it says. There will have to be more tangible evidence that real progress is being made with prepayment medical plans if people of this country are going to be impressed. This first phase of the AMA's national health program is still having heavy going.

An Illogical Proposal

There have been sharp differences of opinion among physicians as to the most satisfactory type of prepayment medical plan. Some favor the indemnity principle. Others insist that a medical service plan is most satisfactory. There are also those who believe that insurance companies should either underwrite or operate plans approved by medical societies.

Your Observer favors the service plan for a number of reasons, principally because subscribers are assured they will receive the services promised. He has long opposed joint sponsorship of prepayment plans by medical societies and insurance companies. For insurance companies are in business for profit, and plans sponsored by medical societies should not, in his opinion, be undertaken as a commercial venture. If he can be shown to be wrong, he will be the first to urge medical societies to forget about prepaid medicine, allowing insurance companies to take over. But so far as he has been able to discover, these companies have no altruistic intention where prepaid medicine is concerned, and there really is no reason why they should have. In many states, as a matter of fact, they have made this clear by endeavoring to run voluntary non-profit plans out of business. Your Observer, therefore, agrees with the editorial in the May number of *The Modern Hospital*, in opposition to the AMA's stand with respect to approval of medical care plans underwritten and sold by insurance companies.

"The illogic of this proposal is apparent in the desperate aims and atmospheres of Blue Cross plans and insurance companies. Probably nothing would encourage the proponents of government medicine more than to see the wholesome, 'people's choice' complexion of Blue Cross fade into the pallid indifference, mottled with downright suspicion, which characterizes the public attitude toward many forms of insurance.

"The whole strength of those who favor the government plans lies in whatever truth there is in Senator Murray's declaration that 'a vast flood of mail beginning to pour into Washington indicates a tremendous demand throughout the country for a national system of prepaid medical and surgical care.'

"The Senator did not say 'federal system'; he did not say 'government' or 'compulsory.' He said 'national.' There is nothing to indicate that a national system of nonprofit plans sponsored by state medical societies under a strong approval program guaranteeing operation in the public interest, as Blue Cross does, would not meet the demand better than it can be met in any other way.

"Plainly, however, it is doubtful that many who are demanding a national system are going to hold still for an answer that includes insurance which may cost 30 or 40 or 50 cents of the premium dollar to sell and administer. AMA standards do include a reference to 'maximum benefits,' but, naturally, a third party whose interest is in making profits will not often return as high a proportion of income in benefit payments as will a non-profit plan whose whole reason for existence is the satisfaction of public need for prepayment protection.

"Apparently, the AMA believes that all sorts of insurance company plans can be tied together with the loose string of medical society sponsorship and then presented to the public as a national package. It won't work. If the doctors really want to give the public a voluntary medical insurance plan, they'd better get busy and set up some honest-to-goodness standards. If they don't, they might as well say so. Half-hearted measures which look both ways on the important principle of non-profit public service are an invitation, not an answer, to government control."

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Medicine's Man from Missouri

Representatives of organized medicine have had rough going before Congressional committees. In no small degree, this has been due to the fact that few committee members sympathetic to its point of view have been willing or interested enough to take up the cudgel in its behalf. This is no longer true, for in the person of Senator Forrest C. Donnell of Missouri organized medicine has an ardent defender and advocate. The Editor of *The Bulletin of the Hennepin County Medical Society* (Minneapolis, Minnesota) pays well deserved tribute to the Senator in the following words:

"While other members of the committee have remained away from the sessions, Senator Donnell has gained an 'A' in attendance—and, more important, an 'A' in the gentle art of cross-examination. With courteous persistence which must have exasperated proponents, the gentleman from Missouri has patiently ex-

> ploded one misrepresentation after another, shot holes in arguments, torn aside the camouflage of impressive names of organizations with unimpressive memberships, forced witnesses to admit they had not read the Bill and generally created and sustained a high degree of confusion among witnesses for the opposition. Almost single-handedly, Senator Donnell has so damaged the bandwagon of political medicine that it is doubtful that it can be repaired sufficiently to roll again in the immediate future. Senator Donnell merits Honorary Membership in every medical organization in America."

Your Observer has attended numerous hearings of the Senate Committee on Education and Labor, and he has come to have admiration and respect for Senator Donnell. The Senator seems to have inexhaustible patience and never loses his temper. Senator James E. Murray, Chairman of the Committee, has at times complained because of the thoroughness with which witnesses have been questioned. He has reminded Senator Donnell that courtroom practices are out of place at hearings of Congressional committees. Senator Donnell listens courteously but is not sidetracked. He politely but firmly proceeds with his questioning. Supporters of organized medicine who have listened to Senator Donnell take antagonistic witnesses apart have had something to cheer about.

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All the Traffic Will Bear

Some years ago your Observer had occasion to discuss with a nationally-known medical leader the threat of Government medicine. This physician was much perturbed because of the commercialism evident among a minority of the medical profession. He said nothing he knew of would stimulate the demand for Government medicine more than excessive fees. He cited several instances to support his view. This conversation came to mind when your Observer read an editorial on the subject, "Are Doctors Responsible for the Threat of Socialized Medicine?" appearing in the June 22 number of *Philadelphia Medicine.* It appears that the editor of this publication had been discussing the subject with the general manager of a large department store in another city. Socialized medicine, this executive said, was inevitable, and it was all the doctors' fault. He thought that physicians "with only a small minority making up the exception, have had little regard for the size of family incomes and have made the cost of medical service so high that people now demand it be taken over by Government so as to be within the reach of all."

Taking exception to this view, the editor argues that physicians know that such conclusions are not correct. He calls attention to the fact that in cities dispensaries are manned by doctors without remuneration; that in rural communities where there are no dispensaries, doctors never refuse to render medical attention because of lack of funds, and that on the whole, physicians are traditionally a philanthropic group. Moderate income families in cities or in the country, he insists, can always find physicians willing to treat them for fees within their ability to pay.

> "While most physicians are more concerned about their patients' illnesses than they are about their own incomes," he says, "it is unfortunately true that there is a small minority of mercenary doctors constantly trying to get all the traffic will bear out of their patients. The Mr. X referred to above has had some experiences with this type of doctor which is the basis of his feeling against all doctors. For example, he cites letters from physicians to his store asking it to collect medical bills from employees who because of long illness are clearly unable to pay. The writer, too, has known of excessive charges by doctors that certainly did not make any friends for the profession. There is no question but that the viewpoint of Mr. X has been distorted by the relatively few wrong kind of doctors with whom he has had dealings. Were he a lone individual his viewpoint would make little difference, but he makes one wonder if there might not be a large number like him who forget the many high-minded members of our profession and can only remember those whose love of money has blinded them to the public weal—and ultimately their own best interests."

The editor believes that whether or not the executive with whom he talked is correct, the medical profession must continue to endeavor to waken the public to the dangers of socialized medicine. He is among those who are convinced that voluntary sickness insurance has great possibilities, and that such legislation as the Wagner-Murray-Dingell bill is "anti-American and must be crushed for the good of America."

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". . . Dynamic, Organized Attack. . . ".

"A healthy sign from the viewpoint of the medical profession is the dynamic, organized attack on these proposals spearheaded by the National Physicians Committee." Thus Dr. Vincent T. Williams, Editor of the *Jackson County Medical Weekly Bulletin* (Kansas City, Missouri), for June 22, describes efforts to defeat the Wagner-Murray-Dingell bill.

Your Observer usually is in agreement with Dr. Williams, but he cannot go along with him on the NPC. For this organization, in your Observer's opinion, does not rate top billing as the "spearhead" in the "attack" on legislation objectionable to the medical profession. The AMA still holds that spot without any close runner-up.

What indirectly inspired Dr. Williams' statement was the announcement that the British Government had adopted the widely discussed complete health service program. In this connection he wonders where the British Medical Association "has been for these many years (well over a quarter of a century) when they must have known that ultimately their Government intended to take over the practice of medicine, the hospitals, and all allied professions." The answer to that is that of course they knew. And as everyone knows, the BMA has fought regimentation of the medical profession down through the years just as the AMA is doing this side of the Atlantic. Only time will tell whether we will fare better.

Coming back to Dr. Williams' observation with respect to NPC, he enlarges upon his views as follows: "Fortunately, we still have in this country a great group of people whose fears of more and more governmental intervention in private affairs are being amply substantiated by current events. We have great and powerful organizations to combat these pragmatists in Washington in the National Physicians Committee, in the AMA and in our various State Medical Associations. We are not as impotent apparently as our British cousins. However, we must not be lulled into a false sense of security. The men who frame these bills are clever and treacherous. Each successive edition of the Wagner, Murray, Dingell proposition has been altered adroitly and cunningly as if to remove some of the stigma of previous proposals. However, on close scrutiny the central theme remains intact: control of the medical care of all our citizens out of Washington."

Your Observer reiterates that the NPC has no standing in Washington comparable to that of the AMA, nor is it anywhere near as effective. In his view, it is regrettable that the AMA is not the lone spokesman for the medical profession. "Outside" organizations are not needed. They merely weaken medicine's hand.

Dr. Williams speaks of the proponents of the Wagner-Murray-Dingell bill as being "clever and treacherous." These are harsh words. In the opinion of your Observer, such statements are not only unjustified but harm the cause of organized medicine. Surely proponents of this legislation have a right to express their views, wrong though they may be, and it must be expected that they will endeavor to win support for their legislation just as opponents seek by every means to defeat it.

Dr. Williams really came out swinging in this editorial, and your Observer is afraid that his temper got the best of his judgment.

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Footnotes

As time goes on, most physicians will become familiar with the recently organized Associate Medical Care Plans, incorporated under the laws of the state of Illinois "to promote establishment and operation of such nonprofit, voluntary medical care plans throughout the United States and Canada as will adequately meet the health needs of the public and preserve and advance scientific medicine and the high quality of medical care rendered by the medical profession of the two countries." A board of directors of the corporation known as the Prepayment Plan Commission has been directed to undertake research and compilation of statistics; establish consultation and information services based on contacts with existing and contemplated plans concerning administrative policies and procedures; promote public education by interpreting the national scope and significance of the medical care plan movement under medical society auspices; and to develop coördination and reciprocity among plans with reference to transference of subscribers and benefits. The AMCP will give its seal of approval to plans which comply with "the minimum standards for medical service" approved by the AMA's Council on Medical Service. . . . One of the most attractive and stimulating medical publications in the country is the *Connecticut State Medical Journal.* The Journal completed ten years of publication in July. Congratulations to Editor Weld, who has done a most excellent job. . . . Many physicians will recall Stephen McDonough, former science editor for the Associated Press, who for many years lived in Washington. "Steve," an unusually capable reporter, highly respected by all who knew him, died suddenly at Rochester, Minnesota, on June 29. A quiet, kindly, retiring man, he won friends readily and kept them. Your Observer will be among many Washingtonians who will miss "Steve.". . . . Just a reminder that there is an ample supply of the new Workmen's Compensation Fee Schedule at the Society's office. Members doing industrial work can obtain these copies by calling the Society's office, requesting that they be mailed to them. . . . Like all employers, the Society has had difficulty obtaining qualified personnel. During the war, the situation was desperate. Several who applied for positions had no training or had never worked in an office. It was reported that the Government employed many persons as typists who had only a fleeting acquaintance with a typewriter. It would seem that this is still true from a news report appearing in the *Washington Daily News* for July 31. The report stated that 51 per cent of the 32,000 Washington residents (all but 1,000 Government employees) who took the recent Civil Service examination for stenographers and typists failed to pass. Arthur S. Flemming, Civil Service Commissioner, quickly pointed out that the fact Government employees flunked would not necessarily mean they would be fired immediately. In fact, he said, they will be retained so long as the present shortage in office personnel exists. . . . According to dispatches from London, George Bernard Shaw has little confidence in doctors. In a lengthy letter to Aneurin Bevan, Minister of Health, he warned that by permitting the General Medical Council to be made up solely of medical practitioners, he risked wrecking Britain's new national health service plan. He observed that the function of the Council is to protect patients against abuse of doctors' powers. "At present the GMC consists of practicing doctors exactly as if the prison commissioners were practicing burglars and murderers," Mr. Shaw asserts. "It is a professional association of the worst type, a hundred years out of date scientifically." Shaw never tires of making the headlines, even at ninety.

T. W.

MEETINGS

Monday, Tuesday, Wednesday, September 30, October 1 and 2

17TH ANNUAL SCIENTIFIC ASSEMBLY

See program elsewhere in this issue.

Wednesday, October 16

The Section on Pathology and Laboratory Medicine will present the program. Speakers and subjects to be announced.

Wednesday, October 30

The Washington Heart Association will sponsor the program. Speakers and subjects to be annouced.

MEDICAL SERVICE OF THE DISTRICT OF COLUMBIA

The following is a description of the medical service plan developed by the Medical Society's Committee on Medical Care and adopted by the Society at a special business meeting on June 19, 1946.

Since its adoption, members of the Society have been canvassed to determine how many will participate. The response has been most satisfactory, replies having been received from 407 physicians as of August 6, 1946. Only 20 have stated that they do not wish to become participating physicians. Returns are still being received, and it is expected that a majority of members will reply before the organization meeting to be held later in September or early in October.

Immediately following the election of officers and a Board of Trustees, a conference will be sought with officials of Group Hospitalization, Inc., in expectation that an agreement can be reached whereby Group Hospitalization will assume the responsibility for the administration of the business affairs of the SERVICE.

The plan described below is a modification of the one originally presented to the Society. However, changes made have been of a minor nature except for the income levels feature. It is understood, of course, that as the SERVICE enters the organization and finally the operation stage, there will of necessity be further modifications.

The schedule of fees for physicians will be mailed to members agreeing to participate. Certain changes were made with the Society's approval; others will be considered when the SERVICE begins to function.

Because of current economic conditions, neither the subscribers' dues nor the physicians' fees are necessarily fixed. Adjustments will be made, keeping in mind the actuarial soundness of the plan.

NAME AND OBJECTIVES

The plan shall be known as MEDICAL SERVICE OF THE DISTRICT OF COLUMBIA.

Health needs in Washington differ from those existing elsewhere. The committee on Medical Care, in developing the SERVICE, has taken this into account.

The Committee's objectives are as follows:

1. To provide surgical and obstetrical services, supplemented by X-ray, laboratory, and anesthetists' services in the hospital, to subscribers to the SERVICE.

2. To guarantee to subscribers free choice of physician, providing the physician chosen has agreed to participate in the SERVICE.

3. To guarantee to physicians free choice of patient among subscribers to the SERVICE.

4. To spread the cost of catastrophic illnesses so that they will not be a burden to any individual.

5. To expand the services provided to include medical as well as surgical, obstetrical, X-ray, laboratory, and anesthetists' services in the hospital.

Inclusion of medical service will be given immediate consideration, it being recommended that the following steps be taken:

(a) That provision be made immediately for compensating participating physicians for medical conditions complicating obstetrical and surgical cases in the hospital.

(b) That prompt study be made in anticipation of including pre-surgical diagnosis, prenatal and postnatal care in obstetrical cases, cystoscopy, adenoidectomy and tonsillectomy in the office.

(c) That study be also undertaken with the view of providing medical service in the hospital.

ORGANIZATION

The organization sponsoring the SERVICE shall consist of physician-members of the Medical Society of the District of Columbia who volunteer to become members of the association, which shall be incorporated under the laws of the District of Columbia, for the purpose of providing surgical and obstetrical services, supplemented by X-ray, laboratory, and anesthetists' services in the hospital to subscribers. They shall elect a Board of Trustees who shall be responsible to the membership for the conduct of the SERVICE. The Board shall adopt by-laws and also such regulations as may be necessary, shall elect the required officers and create such committees as may be necessary to permit wise and expeditious operation of the plan. Because of its legal nature, the control of the assets of the SERVICE and the power to contract with physicians, applicants for participation in the plan, Group Hospitalization, Inc., and others will be vested in the Board of Trustees.

It is recommended that the Board of Trustees shall consist of the following:

1. A member nominated by the United States Public Health Service.
2. Two members nominated by the Washington Metropolitan Health Council.
3. A member nominated by the District Health Department.
4. Seven members nominated by the Medical Society of the District of Columbia.

The Secretary of the Medical Society of the District of Columbia shall be an ex officio member of the Board of Trustees *without a vote.*

Board of Trustees

The operation of MEDICAL SERVICE shall be the responsibility of its Board of Trustees; however, the Board may contract with Group Hospitalization, Inc., to administer the plan under such terms and conditions as may be agreed upon.

Experience has demonstrated that the most satisfactory arrangement is one in which medical and group hospitalization plans retain their separate organizational identities but are administered by a single staff. Group Hospitalization, Inc. is firmly established, with more than 336,000 subscribers. It is very efficiently administered. This is a happy situation. Obviously, administration of the SERVICE by Group Hospitalization, Inc. would do much to assure its success.

Committee on Physicians' Services

The functions of the Committee on Physicians' Services shall be to protect the interests of subscribers to the SERVICE and of participating physicians. This would be accomplished in the following manner:

1. The committee will review and approve payment of bills other than those of a routine nature submitted by physicians for services rendered to subscribers.
2. It will review and adjudicate complaints involving patients and physicians.

Appeal may be made from decisions of the Committee to the Board of Trustees, whose decision shall be final.

The Committee will be composed of three members of the SERVICE appointed by the Board of Trustees for the term of one year.

OPERATION OF THE SERVICE

Medical Services Provided

Subscribers will be entitled to the following services:

1. Surgical and obstetrical services rendered in the hospital.
2. Laboratory services rendered in the hospital to those receiving surgical and obstetrical care.
3. X-ray services in the hospital to those receiving surgical and obstetrical care.
4. Anesthetists' services in the hospital to those receiving surgical and obstetrical care.

It is recommended that the cost of the services which the subscriber receives under this program in any one year shall not exceed $300 per single person, $400 per husband and wife, and $500 for a family. There shall be a $1 registration fee.

Limitations and Exclusions

1. The SERVICE provides only surgical and obstetrical services, supplemented by laboratory, X-ray, and anesthetists' services in the hospital under conditions previously stated.
2. Subscribers will not be entitled to obstetrical care and such operative procedures as tonsillectomy, adenoidectomy, herniotomy, and hemorrhoidectomy for the first ten months.
3. Treatment for conditions known to exist at the time of application is excluded.
4. Also excluded are any medical services available without cost to the subscriber under workmen's compensation laws.

General Provisions

The form of the subscribers' contract and provisions relating to conditions of enrollment, term of contract, and all general provisions except those pertaining to benefits will parallel those of Group Hospitalization. In addition, 50 per cent of all eligibles in any employed group must subscribe to be acceptable.

Subscribers' Dues

Subscribers will pay dues in advance on a monthly basis, closely approximating, if not identical, to those of Group Hospitalization, Inc.

Subscribers' dues shall be as follows, subject to such changes as are found necessary:

Single person	$0.75 per month
Subscriber-Spouse	1.50 per month
Subscriber-Spouse and Dependents under 18 years of age	1.75 per month

Participation of Physicians

Medical service will be rendered subscribers by members, Active, Life, and Associate, of the Medical Society of the District of Columbia who agree to participate. Physicians living in the nearby communities of Virginia and Maryland who become Associate members are eligible to render service under this program.

Qualifications of physicians participating in the SERVICE shall be determined by their privileges in any hospital approved by the American Medical Association or the American College of Surgeons.

Any participating physician reserves the right to decline to render service to a subscriber, and a subscriber in turn is privileged to discharge a physician in the same manner as is now done in private practice, with due regard for the responsibilities of MEDICAL SERVICE to serve subscribers.

Physicians participating in the SERVICE shall be subject to the same professional and ethical requirements as are set forth in the Constitution and By-laws of the Medical Society and the Principles of Medical Ethics of the American Medical Association.

Physicians participating must agree to conform to the rules governing the operation of the SERVICE, a copy of which will be provided, and to render such assistance as may be necessary to make the plan function efficiently.

Physicians will be provided with certificates bearing their names and indicating their participation, to be displayed in their offices, so that subscribers may be assured of their acceptability to the SERVICE.

Physicians' Fees

Fees listed in the schedule submitted to and approved by the Society shall be considered full compensation except where the individual subscriber has an income exceeding $2500, or where the individual subscriber and his or her family have an income exceeding $4500. In both instances, the fees listed may not be considered as being full payment of the physician's services. The physician and the subscriber will agree on a charge for the services rendered, and the fees listed will be applied on the physician's bill.

REPORT OF THE DELEGATE TO THE AMERICAN MEDICAL ASSOCIATION

The first postwar meeting of the American Medical Association, held in San Francisco, was well attended, the registration exceeding by a considerable number that of the 1938 session, in the same city. Notable was the constructive action taken by the House of Delegates on a number of important matters.

Two Delegates from the District of Columbia

The current year, 1946, is the year for reapportionment of delegates. Because the total voting strength of the House of Delegates by constitutional provision cannot exceed 175, the membership quota per delegate is reapportioned triennially. Apportionment at this session was made on the basis of one delegate per 1,000 members and fraction thereof for each constituent body. Our membership rolls, as reported to AMA headquarters in April, 1946, showed 1,037 Active members. Dr. George F. Lull, Secretary, announced that this will automatically give the District Medical Society an additional delegate.

Prepayment Plans

The report of the Council on Medical Service and Public Relations*, also the Council's supplementary report with respect to its recent activities, was referred to the Reference Committee on Legislation and Public Relations. The Reference Committee in its report to the House, which was accepted, gave general approval to the Council's activities with special commendation for certain specific items. Pursuant thereto comprehensive procedures are under way which will have far-reaching effect in the field of Medical Service Extension. The Medical

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* By action of the House of Delegates, now known as Council on Medical Service.

Society of the District of Columbia may well take pride in the fact that it has stanchly been a proponent of the AMA's taking the lead in the development of a National Health Plan with emphasis on prepayment medical plans. The following are specific steps in elaboration of this theme which have now been taken under the development and guidance of the Council on Medical Service, Dr. Edward J. McCormick, Chairman:

1. There is established a subdivision of the Council known as "Prepayment Plans and Associated Care Plans" with a full-time Director.

2. A new brochure is available, "Voluntary Prepayment Medical Care Plans," which contains up-to-the-minute actuarial figures and information on insurance organization pro and con.

3. Amendments have been adopted to the established STANDARDS OF APPROVAL clarifying the control to be exercised by the medical profession and also giving an important interpretation to no. 6 which reads, "The Plan should be organized and operated to provide the greatest possible benefits in medical care to the subscriber. Honesty of purpose and sincere consideration of mutual interests on the part of subscribers, the physicians, and the plans are presupposed as necessary considerations for successful operation." (The latter received special commendation by the Reference Committee.)

4. Provision is now made for giving of an official seal to plans (not companies) which conform to the STANDARDS OF APPROVAL as amended, "The Seal of Acceptance denotes that ____________ has been
name of plan
accepted within the standards set forth by the Council on Medical Service of the American Medical Association."

REORGANIZATION OF HEADQUARTERS OFFICE

The Board of Trustees reported that the survey of the AMA's public relations program had been completed by expert consultants employed for this purpose, and as a result certain changes had been recommended. These recommendations were carefully considered and approved by a reference committee and later adopted by the House of Delegates with minor changes. Pursuant thereto the California delegation withdrew certain resolutions they had introduced which had to do with public relations and the Chicago office.

The Board of Trustees' recommendations now in effect are:

1. That an economist of high standing be obtained to head the Bureau of Medical Economics.

2. That an Executive Assistant to the General Manager of the AMA in charge of public relations be employed, and a Division of Public Relations in the Headquarters Office be established, with sufficient personnel, under the direction of the General Manager and the Board of Trustees. (The purpose of this arrangement is to coördinate all activities of the Association, other than scientific, relating to the public, and to prevent overlapping and duplication of duties.)

It seems appropriate to quote briefly from the report made by the consultant employed by the Board of Trustees to survey the public relations program of the AMA. That the statement confirms the attitude of our own Society is most evident.

"The consultant feels that for many years the position of the Association on economic and social aspects of medicine has been defensive and negativistic. Now he feels that the Association has a positive health program, including a nation-wide distribution of medical care based on the voluntary insurance system, and that is its greatest potential asset."

ELECTION OF OFFICERS

Dr. Olin West was the unanimous choice of the Delegates for President-elect. This came as a well deserved honor for one who has proved himself a true friend of the doctor and a stalwart in the cause of maintaining the American system of medical practice.

Other officers elected by the House were Dr. E. V. Bortz, Vice President; Dr. George F. Lull, Secretary; and Dr. Josiah J. Moore, Treasurer.

A contest developed in the election for the important office of Speaker of the House of Delegates. Dr. R. W. Fouts of Nebraska received 90 votes to 77 polled by Dr. Lowell S. Goin of California.

COMING MEETINGS

It was announced that the following meetings of the AMA had been scheduled for 1947 and 1948:

Atlantic City, New Jersey, June 9–13, 1947; and St. Louis, Missouri, May 10–14, 1948.

The House of Delegates adopted a recommendation to hold two sessions annually. The next session will be held in Chicago in December.

Legislative Matters Considered in Committee

Your delegate was in attendance at all meetings of the House of Delegates, as was Theodore Wiprud, Secretary of the Medical Society of the District of Columbia. It is to be noted also that Dr. William P. Herbst, Jr., President of the Society, was in attendance at several sessions. The meetings of the Reference Committee on Legislation and Public Relations, Dr. Edwin S. Hamilton, Illinois, Chairman, also required your Delegate's attendance. The part of the report of the Board of Trustees referring to legislation and the reports of the Council on Medical Service were among the items considered by this committee. Adverse opinion on S.1606 and on S.1318 (Pepper Bill) was given. The Taft Bill (S.2143) was considered still in the formative stage. The Committee approved the Hill-Burton Bill (S.191). Concerning H.R. 6178 (the Rogers Bill), the position was taken that all regulations of the barbiturates should be at the state level. The Reference Committee's report was accepted by formal action of the House.

Your delegate, by action of the Executive Board, was appointed Alternate Delegate to the Round Table on Public Relations, which was held in San Francisco, July 3.

Stimulation of Attendance of Fellows at AMA Meetings

Your delegate believes that every effort should be made to gain a large attendance of the Society's members at every AMA meeting. The fact that members are welcome at meetings of the House of Delegates is not generally known. Even in executive sessions the rules are elastic enough to admit Fellows of the AMA who are actively interested in subjects under discussion. It is recommended that members of the Society be urged to attend AMA meetings and the meetings of the House of Delegates; also that a list of members who attend the AMA meetings be routinely published in the Medical Annals.

Respectfully submitted,
C. B. Conklin, M.D.
Delegate

Calendar of Meetings

August 2	Attendance Committee, Annual Scientific Assembly
August 5	Committee on Arrangements, A. S. A.
August 12	Committee on Public Meeting, A. S. A.
	Special Traffic Committee
August 13	Committee on Scientific Exhibits, A. S. A.
August 14	Committee on War Souvenirs Exhibit, A. S. A.
August 16	Committee on Social Affairs, A. S. A.
August 19	Special Traffic Committee
August 21	Program Committee
August 23	Committee on Scientific Exhibits, A. S. A.
	Committee on Social Affairs, A. S. A.
August 26	Executive Board
	Attendance Committee, A. S. A.
August 28	Grievance Committee

MEMBERSHIP

The following applicants for membership were duly elected to membership at the meeting of the Executive Board, July 29, 1946, in accord with Amendment XI, Section 2, of the Constitution and By-laws of the Society:

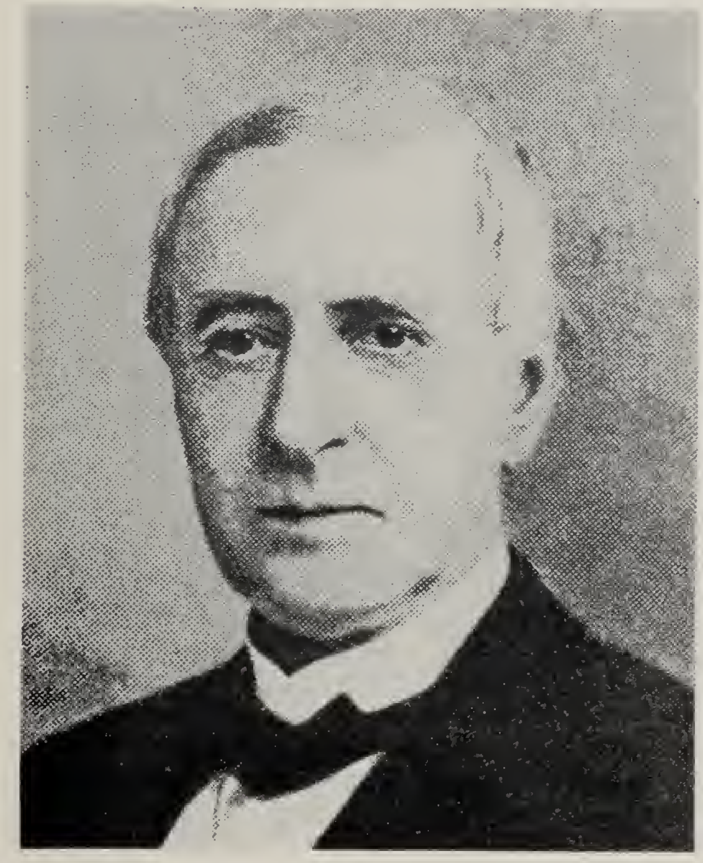
Active Members

Joseph F. Belair, Providence Hospital
Alfred H. Benson, 1835 Eye Street, N.W.
Raymond F. Chinn, 1801 Eye Street, N.W.
William S. Derrick, 8200 Nolte Avenue, Silver Spring, Md.
William Frank, 2319—40th Place, N.W.
Alfred R. Greenfield, 924—19th Street, N.W.
Dean M. Hayes, 1726 M Street, N.W.
Maurice H. Herzmark, 1612 Rhode Island Avenue, N.W.
William L. Howell, 1801 Eye Street, N.W.
Benjamin P. Lafsky, 2025 Eye Street, N.W.
Sidney W. Lowry, 1503 Good Hope Road, S.E.
Thomas F. McMahon, 1836 Varnum Street, N.E.
Carlton N. Price, 1801 K Street, N.W.
Alvin Seltzer, 2025 Eye Street, N.W.
Harold Sterling, 2100 Connecticut Avenue, N.W.
George J. Stuart, 1150 Connecticut Avenue, N.W.
Charles S. White, Jr., 2310 Kalorama Road, N.W.

Associate Members

Hanson T. Perkins, 4115 Wisconsin Avenue, N.W.
James W. Sinclair, 1801 K Street, N.W.
George R. Spence, 509 Dartmouth Street, Silver Spring, Md.

Washington Physicians of Yesterday



WILLIAM PATRICK JOHNSTON, M.D.

The first physician in Washington to devote special attention to diseases of women, Dr. William Patrick Johnston, was also one of the most highly respected and successful medical practitioners in the Nation's Capital in the 1850's. He not only had a large practice, but was prominent in the civic affairs of the community. During the years 1856 to 1858, he was President of the District's Board of Health.

Dr. S. C. Busey says of Dr. Johnston, "He was one of a coterie of influential and distinguished medical men who during their active lives asserted themselves in all the relations of good citizenship, not for personal aggrandizement, but in the maintenance of the dignity and influence of the medical profession."

Dr. Johnston was born June 11, 1811, in Savannah, Georgia. He was educated at the Round Hill School, Northampton, Massachusetts, of which George Bancroft was then the head. He received his A.B. degree at Yale in 1833, and his M.D. degree from the University of Pennsylvania in 1836. During the years 1837 to 1840 he traveled in Europe, in the course of which he studied in Paris hospitals. He began the practice of medicine in Philadelphia, but after marrying Miss Hooe of Alexandria, D.C., in 1840, he settled in Washington. He became Professor of Surgery, Columbian Medical College, in 1842, and Professor in Obstetrics and Diseases of Women and Children at the same institution in 1845. He resigned in 1871.

Dr. Johnston died October 24, 1876, of chronic heart disease. Old newspaper files reveal that people throughout Washington mourned the passing of this kindly and able physician.

Veterans' Affairs

COLONEL SCHNEIDER CITED FOR OUTSTANDING SERVICE

An Oak Leaf Cluster to the Army Commendation Ribbon was recently awarded to Lt. Colonel Leo V. Schneider, Chief Tuberculosis Consultant for U. S. Military Government in Germany, for "outstanding and meritorious service from October 25, 1945 to April 19, 1946." The citation read in part:

"Through your unrelenting and persistent efforts and by application of your thorough knowledge and training, the necessary organization for the resumption of effective case finding, isolation and treatment of tuberculosis by the German Health Authorities has been reëstablished.

"Your initiative, diligence and devotion to duty have accomplished results which reflect great credit upon yourself and the Army of the United States.

"In your capacity as Consultant to the United States Member of the Allied Health Committee you have, through your tact and diplomacy, greatly facilitated the work of the United States Government and have helped create a spirit of friendliness and coöperation between the four powers now occupying Germany."

Dr. Schneider graduated from Donskey University, Russia, in 1920, and from Johns Hopkins University School of Hygiene and Public Health in 1934. He entered the Service on October 17, 1942.

PROMOTIONS NOT PREVIOUSLY REPORTED

The following promotions in rank for members of the Medical Society have not previously appeared in the Medical Annals:

Theodore J. Abernethy, from Major to Lieutenant Colonel
Richard B. Castell, from Lieutenant to Lieutenant Commander
William D. Chase, from Captain to Major
Frank E. Gibson, Jr., from Major to Lieutenant Colonel
Donald H. Leeper, from Captain to Major
Philip Litvin, from Major to Lieutenant Colonel
Ivy A. Pelzman, from Lieutenant Colonel to Colonel

PHYSICIANS CONTINUE TO RETURN TO WASHINGTON

Since publication of the last list of returned service physicians in the July Annals, the following physicians have returned to civilian life, most of them to resume private practice in Washington:

Theodore J. Abernethy, 1834 Eye Street, N.W.
George L. Ball, 7835 Eastern Avenue, Silver Spring, Md.
Percy A. Bryant, Bay Minette, Alabama
Charles P. Cake, 3408 Wilson Blvd., Arlington, Va.
C. Willard Camalier, Jr., 1746 K Street, N.W.
Richard B. Castell, Mayflower Hotel
William D. Chase, Veterans Administration Center, Reno, Nevada
Charles S. Coakley, 1746 K Street, N.W.
Charles F. Forester, 1224 M Street, N.W.
Frank B. C. Geibel, 3501 Monroe Street, Columbia, S. C.
A. Clagett Gray, 1242 Newton Street, N.E.
Irvin Hantman, 900 17th Street, N.W.
Dean H. Harding, 113 Carroll Avenue, N.W.
David F. Hodge, 3104 Ravensworth Place, Parkfairfax, Alexandria, Va.
Charles R. Hughes, 900 17th Street, N.W.
Donald H. Leeper, 1801 Eye Street, N.W.
Philip Litvin, 3433 14th Street, N.W.
William C. Manion, Casualty Hospital
Ivy A. Pelzman, Shoreham Hotel
Leo V. Schneider, Glenn Dale Sanatorium
Richard H. Spire, 2100 N. Capitol Street
John C. Sullivan, 2023 38th Street, S.E.

News and Personals

The American College of Physicians announces a series of 13 postgraduate courses to be given this fall in various cities of the United States and Montreal, Canada. Five of these courses, including the one scheduled for Washington, D.C., will be devoted to Internal Medicine. Other courses will deal with Psychosomatic Medicine, Clinical Neurology, Clinical Medicine from the Hematologic Viewpoint, Allergy, Recent Advances in the Diagnosis and Treatment of Cardiovascular Disease, Gastroenterology, Bacterial Chemotherapy and Cardiology.

These courses are made available by the College to its members at minimum cost. Where facilities are available, the courses will be open to non-members with adequate preliminary training. Registrations from non-members of the College may not be accepted more than three weeks in advance of the opening of any course. Fees for members are $20.00 per week; for non-members of the College, $40.00 per week. Registrations should be filed directly with the Executive Secretary, E. R. Loveland, 4200 Pine Street, Philadelphia 4, Pa. Requests for hotel accommodations in Washington, D.C., should be made to Dr. Joseph T. Roberts, Gallinger Municipal Hospital, Washington 3, D.C.

Dr. Wallace M. Yater is Director of the Course on Internal Medicine to be given at Gallinger Municipal Hospital during the two weeks, October 21–November 1. Assisting Dr. Yater on the Program Committee are Colonel Charles R. Mueller and Drs. Walter K. Myers, Hugh H. Hussey, Jr., James J. Griffitts and Roberts.

Officers of instruction, in addition to the above committee, are the following physicians, most of whom are members of the District Medical Society:

Drs. Theodore J. Abernethy, Charles Armstrong, Garnet W. Ault, William M. Ballinger, Joseph M. Barker, E. E. Barksdale, G. J. P. Barger, Harry S. Bernton, Brian B. Blades, Frederick J. Brady, Norman Q. Brill, Grafton T. Brown, Frederick G. Burke, Paul Chodoff, Arthur C. Christie, William Earl Clark, Milton Cobey, Robert J. Coffey, Darrell C. Crain, William J. Cusack, Worth B. Daniels, Edgar W. Davis, Robert F. Dow, Harry F. Dowling, Addison M. Duval, James J. Feffer, Edward Francis, Walter Freeman, Nathan B. Friedman, Fred A. J. Geier, William T. Gibb, Jr., Ira Gore, James N. Greear, Robert H. Groh, Roscoe W. Hall, Aubrey O. Hampton, Dean M. Hayes, William P. Herbst, Robert P. Herwick, Emil J. C. Hildenbrand, Pearl B. Holly, John P. Hubbard, Harold J. Jeghers, Sol Katz, Solomon Katzenelbogen, Thomas F. Keliher, Clapham P. King, Morris Kleinerman, Calvin T. Klopp, Vasilios S. Lambros, Carl L. Larson, Preston A. McLendon, Maurice Mensh, Sidney Olansky, Byron J. Olson, Raymond F. Osborne, Winfred Overholser, John L. Parks, Russell C. Payne, Matthew White Perry, Andrew G. Prandoni, Lawrence E. Putnam, Harold R. Reed, John A. Reisinger, E. Clarence Rice, Isadore Rodis, Joseph H. Roe, Bertram F. Schaefer, William H. Sebrell, Joseph P. Shearer, Edward J. Stieglitz, Robert Stolar, Donald H. Stubbs, George James Stuart, Lewis K. Sweet, Walter O. Teichmann, Lawrence J. Thomas, Norman H. Topping, John W. Trenis, Harriet E. Twombly, J. Ross Veal, J. Russell Verbrycke, Joseph J. Wallace, Bernard J. Walsh, James W. Watts, J. Edwin Wood and Vincent Young.

Also, Brigadier General George R. Callender, Director, Army Medical School; Colonel Harold I. Amery, Captain William W. Engstrum, Lt. Colonel Milton Friedman, Major Alvin Hulnick, Colonel Lloyd G. Lewis, Captain Monroe J. Romansky, and Captain George W. Soffe, all from Walter Reed General Hospital; Major Richard P. Custer and Captain D. F. Mullins, Jr., of the Army Institute of Pathology; Captain Erik G. Haakanson, of the National Naval Medical Center; Captain L. R. Newhouser, of the Professional Division, Bureau of Medicine and Surgery; and Dr. James Bordley III, Associate Professor of Medicine, Johns Hopkins University School of Medicine, Baltimore.

The American Board of Obstetrics and Gynecology will hold the next written examination (Part I) for all candidates in various cities of the United States and Canada, on February 7, 1947, at 2:00 p.m. All applications must be in the office of the Secretary by November 1, 1946.

A number of changes in Board regulations and requirements were put into effect at the last annual meeting of the Board. Case records must now be forwarded to the Secretary's office from 30 to 60 days after the candidate has received notice of his eligibility for admission to the examinations for certification. The Board also ruled that it will not accept the nine months' residency as an academic year toward years of training requirements following the termination of the official period of intern and residency acceleration, April 1, 1946.

Applications are being received for the 1947 examinations. Final examinations will be held in Pittsburgh, Pa., June 1–7, 1947. For further information and application blanks address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh 6, Pa.

The Eleventh Annual Assembly of the United States Chapter of the International College of Surgeons will be held in Detroit, October 21–23. The Detroit Statler and the Book-Cadillac will be hotel headquarters. For information concerning the Assembly or for prerequisites for fellowship in the United States Chapter of the College, write to Dr. L. J. Gariepy, Secretary, 16401 Grand River Avenue, Detroit 27, Michigan.

The Eighth Annual Exhibition of the American Physicians Art Association was held in the War Memorial Opera House in San Francisco, July 1–5, 1946. Several Washington physicians were among the exhibitors listed in the official catalog. Dr. Leslie H. French displayed five photographs and Dr. William A. Warfield, Jr., two oil paintings. Dr. L. V. Dill received the Award of Merit, consisting of certificate and silver medal, for a pastel entitled "Portrait of My Wife." Dr. Douglas Noble received the same award for a pastel, "Olney, Maryland," which he exhibited along with two oil paintings, "Deserted Beach" and "The Cave."

As a result of the recent increase in traffic fatalities, President William P. Herbst was requested by George E. Keneipp, Director of the District Department of Vehicles and Traffic, to appoint a special committee of physicians to meet with Mr. Keneipp in an effort to determine the relation of physical handicaps to driving.

Those who met with Mr. Keneipp in the Medical Society's building, August 12, were Dr. Wallace M. Yater, Chairman of the committee; Drs. William M. Ballinger, Herbst, Oscar B. Hunter, Arnold McNitt, Winfred Overholser, William J. Tobin, and Theodore Wiprud, Secretary of the Society. Also present were Lindsey Rider, Chief Permit Examiner of the Bureau of Vehicles and Traffic, and John Mitten, Traffic Engineer of the Bureau.

The committee agreed to draw up a full set of questions designed to give a more accurate picture of the physical background of the applicant than is secured from the present application.

The Hippocrates-Galen Society has elected the following officers to serve during 1946–47:

Dr. George Nutting, *President;* Dr. Hill Carter, *Vice President;* Dr. George Sharpe, Jr., *Secretary-Treasurer.*

During the week, August 12–17, the following members of the Medical Society participated in the professional staff meetings at **Walter Reed General Hospital:** Drs. Arthur C. Christie, Daniel B. Moffett, Worth B. Daniels, Crenshaw D. Briggs, Donald Stubbs and Joseph Kreiselman. Others who appeared on the program were Colonel James S. Taylor, Dr. Brian Blades, Dr. Lloyd G. Lewis, Lt. Colonel James L. Royals and Major Humbert L. Riva.

The following members of the **Woman's Auxiliary to the Medical Society of the District of Columbia** will serve as officers during 1946–47: Mrs. William P. Herbst, *President;* Mrs. Wm. J. B. Orr, *First Vice President;* Mrs. A. Barnes Hooe, *Second Vice President;* Mrs. Richard H. Todd, *Recording Secretary;* Mrs. Leo C. Varden, *Corresponding Secretary;* Mrs. Harry S. Lewis, *Treasurer.*

Robert V. Fleming, Chairman of the Board of Trustees of the **George Washington University Hospital,** announces that a drive will begin in Washington, September 23, to end October 19, for the purpose of raising $925,000 with which to equip the new Hospital.

Dr. Daniel L. Finucane, Superintendent of Glenn Dale Sanatorium, addressed the Civitan Club, July 30, at a luncheon meeting at the Mayflower Hotel. Club members paid silent tribute to Dr. Grant S. Barnhart, a charter member, who died July 25.

Four Medical Society members participated in the radio series, Tomorrow's Washington, over WRC, August 13. Taking part in a roundtable discussion on Washington's hospitals and health facilities were

Dr. William P. Herbst, President of the Society; **Dr. George C. Ruhland,** District Health Officer; **Dr. Alvin R. Sweeney,** Superintendent of Gallinger Hospital; and **Dr. Herbert P. Ramsey,** Chairman of the Washington Metropolitan Health Council.

Miss Bernadette Larme resigned her position as Secretary to Theodore Wiprud on July 31. She was married at Belleville, Wisconsin, August 24, to Mr. Carl Wilhelm of Madison, Wisconsin. Miss Larme was well known to many members of the Society, having been in the Society's employ for the past several years.

Dr. Sidney Olansky, who has served as Medical Officer in Charge of the Rapid Treatment Center at Gallinger Municipal Hospital, will spend the next two years at Duke Hospital, Durham, N. C., where he has obtained a fellowship in dermatology, beginning September 15.

Rear Admiral Dallas G. Sutton, M.C., U.S.N. (retired), joined the Washington Service Bureau of the American Hospital Association on September 1 as director of study of government hospital relations. Admiral Sutton will serve as liaison between the Association and the Federal Government in matters concerning the federal hospital program and will assist in the coördination of civilian and federal hospital facilities. He will also study the entire program of hospital benefits to veterans, including development of veterans' hospitals.

Admiral Sutton received his degree in medicine from George Washington University in 1906, and recently concluded a Navy career of 40 years' duration. He served as Assistant Surgeon General from 1937 to 1941. During 1941 and early 1942 he was commanding officer of the Naval Hospital, Portsmouth, Virginia, after which he was in charge of construction of the Naval Medical Center at Bethesda, Md., erected the same year. From that time until his retirement in April of this year, Admiral Sutton was inspector of all East Coast activities of the Naval Medical Department.

Dr. Thomas McP. Brown, Associate Professor of Medicine at Johns Hopkins University, Baltimore, became Chief of Medicine at Mount Alto Hospital, August 1. Dr. Brown was formerly a Lieutenant Colonel in the Army Medical Corps. He graduated from Swarthmore College in 1929, Johns Hopkins Medical School in 1933, and the Rockefeller Institute in 1938.

Dr. Mary Warner, the first woman physician to serve as chief resident of Children's Hospital, has announced her resignation. She will be succeeded by Dr. John O. Nestor of Newton, N. J., a graduate of Georgetown University School of Medicine. Dr. Nestor is a veteran of World War II and has served as resident physician at Children's for the past 10 months.

In the "Report on the Progress and Condition of the United States National Museum for the Year Ended June 30, 1945," there appears listed as Accession No. 169467 a portrait of Robert Morris, 1734–1806, donated by The Medical Society of the District of Columbia.

CORRESPONDENCE

To the Editor
Medical Annals of the District of Columbia
Washington, D. C.

Re: "Melanotic Moles" by Putzki and Scully

This article contains a number of conclusions and inferences about which there may be great difference of opinion.

In the case reports there may certainly be room for difference of opinion as to the origin of the melanoma. Certainly in both cases one and two it is only an inference, and not proven, that the moles removed by desiccation were the original lesions. In view of the fact that there was no evidence of local recurrence in either case, one would infer that the local removal had been complete, and that if these moles were the primary lesion metastasis had probably occurred before, rather than as a result of, the treatment used.

Second, "The objection to electric cauterization is that tissue is destroyed, and there is no opportunity for microscopic examination." I will be glad to show the authors several dozen biopsies from moles treated by electric desiccation.

The whole inference of the article is that desiccation is more likely to lead to the production of metastatic melanoma than surgery with the knife. However, experience shows that inefficient treatment with either agent is dangerous, but that proper use of either agent is efficient. Electric surgery, by sealing off the lymphatics, should certainly be no more dangerous than knife excision.

I have no criticism of those who prefer surgical excision of moles with the knife. Indeed, I have on occasion referred patients to surgeons for such treatment when it seemed that a better clinical and cosmetic result could be obtained.

It does seem unfair, however, to criticize any particular method of treatment when that method has been used successfully in thousands of cases. I myself have seen several cases of metastatic melanoma following surgical excision of the original lesion by good surgeons. This does not lead me to condemn surgery, however, as I assume the patients would have had the same result no matter what treatment was used, or whether the moles were treated at all.

In my files there are records of 277 patients treated for moles. Many of these had more than one mole removed, and many other patients had moles removed who were in for some other primary complaint. It is possible that some of these patients with malignant melanoma have later been seen by other physicians—indeed it may be that the authors' patients were treated by me—but certainly if many had had serious after-effects I should have heard from them. My principal criticism is that a method of treatment so widely and successfully used should be condemned out of hand because of three unfortunate results which might just as well have occurred after surgery.

It is particularly unfortunate that a résumé of this article appeared in the public press, as it will cause needless mental anxiety to hundreds of patients who have had moles removed by electric surgery.

F. J. Eichenlaub, M.D.

JOHN DANIEL THOMAS, A.B., M.D., F.A.C.P.

(1868–1946)

Dr. John D. Thomas, a Life Member and Past President of the Medical Society of the District of Columbia, died at his apartment at 2115 P Street, N.W., July 15, 1946. He was Emeritus Professor of Physical Medicine at Georgetown University School of Medicine and had been a private practitioner in Washington for fifty years.

He was born in Northampton County, Virginia, August 13, 1868, the son of James Dunlop and Marian Buckey Thomas. He received his A.B. degree from Hampden-Sydney College in 1889, and his M.D. degree from the University of Virginia in 1892. He served as intern and resident physician at Gouverneur's Hospital (branch of Belleview) in New York City, 1892 to 1894. He also enrolled for postgraduate study at the New York Postgraduate Hospital, and took a course in the Vienna General Hospital, Austria. Dr. Thomas established his practice in the District of Columbia in 1895, specializing in internal medicine.

Commissioned a surgeon in the Spanish-American War, he was a Captain in the Medical Corps during World War I.

Dr. Thomas was on the medical staff of Emergency Hospital and the Washington Home for Incurables, visiting physician at Garfield and Georgetown Hospitals, and consulting physician at Mount Alto Hospital. For many years he was Professor of Physical Medicine at Georgetown University School of Medicine, becoming Professor Emeritus in 1924.

John Daniel Thomas, A.B., M.D., F.A.C.P.

Elected an Active Member of the Medical Association of the District of Columbia in 1896, he became a Life Member of the Medical Society on January 1, 1937. In acknowledging conferral of Life membership upon him, Dr. Thomas wrote to Dr. C. B. Conklin, who was then Secretary of the Society, "I do not think I ever attended a meeting of the Medical Society in all these forty years that I have not come away with something to add to my store of knowledge."

Dr. Thomas served the Medical Society in various capacities during his lifetime. He was active on many committees, including the Executive Committee, was elected Vice President in 1905, and President of the Society in 1925. He was also a Fellow of the American Medical Association, and a member of the Medical Society of Virginia, the Clinico-Pathological Society and the Metropolitan Club.

Dr. Thomas never married. His only surviving relative is a cousin, Mrs. Kathryn Crampton, of Washington.

HOWARD FRANCIS KANE, A.B., M.D., F.A.C.S.

(1887-1946)

Dr. Howard Francis Kane, who died on July 21, was born on May 14, 1887, the son of George Wesley and Cora Leighton Kane, Machias, Maine. He graduated from Worcester Academy in 1905. In 1909 he received his A.B. degree from Bowdoin College, and in 1912 he graduated from George Washington University School of Medicine. There followed house staff appointments at George Washington, Children's, Columbia and the New York Lying-In Hospitals. His special interest in obstetrics and gynecology may have been due to the influence of Dr. Ara Davis and Dr. J. Wesley Bovée during this period of training.

Following his appointment as Instructor of Obstetrics and Gynecology at George Washington University School of Medicine in 1916, there ensued a period of teaching and private practice, interrupted by World War I, in which Dr. Kane served with distinction. He entered the Army Medical Corps as First Lieutenant, and was promoted to Captain while serving with the British Expeditionary Forces. For remaining with a group of sixty wounded men after a German break-through, Dr. Kane was decorated with the British Military Cross. He was interned in Germany as a prisoner of war for six months. Discharged with the rank of Major in the Army Medical Reserve Corps, he returned to Washington. On January 28, 1920, he married Miss Clara Bailey, daughter of James and Lucy Bailey of Machias, Maine.

Dr. Kane began the practice of obstetrics and gynecology at a time when this field was assuming a larger scope. His capacity for work and his special interest in this specialty contributed to the great skill he acquired. Following the war he resumed his work on the teaching staff of George Washington University School of Medicine as Associate in Obstetrics. On August 28, 1928, he accepted two additional appointments, Professor of Obstetrics at Howard Univesity School of Medicine and Attending Obstetrician to Freedmen's Hospital, serving for a period of two years.

In 1932, after steady elevation in the Department of Obstetrics and Gynecology at George Washington, he was appointed Executive Officer and Professor of Obstetrics and Gynecology. He was also Chief of the Division of Obstetrics and Gynecology of George Washington University Hospital, Chief of Obstetrics and Gynecology at Gallinger Municipal Hospital, and Senior Attending Obstetrician at Garfield Memorial Hospital.

Blackstone Studios

HOWARD FRANCIS KANE, A.B., M.D., F.A.C.S.

Dr. Kane was appointed by the District Commissioners to the Board of Examiners in Midwifery on December 30, 1929, and during the following year to the Board of Examiners in Medicine and Osteopathy. The latter post was relinquished in 1939 because of the large volume of his practice. His resignation was received with regret by the Commissioners, who praised his generous and unstinted services.

After resigning his reserve commission in the U. S. Army, he was appointed Lieutenant Commander in the U. S. Naval Reserve in 1937. Elevation to the rank of Commander occurred shortly after the outbreak of World War II.

Dr. Kane was a diplomate of the American Board of Obstetrics and Gynecology; Fellow of the American College of Surgeons, American Medical Association, International College of Anesthetists, and American Association of Obstetricians, Gynecologists and Abdominal Surgeons; member of the George Washington University Medical Society, the American Legion, Military Order of Foreign Wars, Zeta Psi, Alpha Kappa Kappa, Sigma Xi, Masonic Lodge (K. T. Shriner), Cosmos, Metropolitan, Gibson Island, Columbia and Chevy Chase clubs. He had been an Active member of the Medical Society of the District of Columbia since 1917.

Dr. Kane gained national recognition for his method of securing analgesia during labor by means of paraldehyde. For this achievement he was granted both the Frank E. Gibson Award by the Washington Medical and Surgical Society, in 1939, and Fellowship in the International College of Anesthetists.

Dr. Kane was associated with Dr. Joseph Kreiselman in the early development of the Kreiselman model infant resuscitator, which is considered by delivery-room personnel everywhere an essential piece of equipment. This apparatus has undoubtedly contributed as much toward the saving of infant lives as any other one thing in the last generation. The Kane umbilical cord-clamp is also widely used.

No account of Dr. Kane's activities would be complete without reference to his active interest in the training of young men in his specialty. He was early concerned with the development of competent obstetricians, and his extreme interest and desire to train younger men is attested by the large number whose privilege it was to work and study under him.

Although his practice was arduous and exacting Dr. Kane's literary output was extensive, he having contributed a total of thirty-five papers to medical journals. A desire to write an obstetrical textbook when time afforded was not achieved. He spoke at many meetings; his humor, tact and good judgment made him an ideal speaker.

Dr. Kane taught and worked assiduously until he was activated in the United States Navy on October 1, 1943. He was appointed Chief of the Obstetrical Division of the U. S. Naval Hospital, San Diego, California. During this tour of duty, his physical disabilities were aggravated, and the first of a series of breaks in bodily resistance was recorded. He returned to Washington and continued service until stricken with a cardiac attack. He was hospitalized at the Naval Hospital in Bethesda about one year ago.

Following partial recovery, he refused to relegate his beloved specialty to a secondary position and accepted the post of Editor-in-chief of the *Quarterly Review of Obstetrics and Gynecology*. Service on this journal was limited to a brief period before his death.

Dr. Kane was appointed Professor Emeritus of Obstetrics and Gynecology of George Washington University School of Medicine, on May 28, 1946. He left shortly thereafter for his beloved birthplace, Machias, Maine.

The foregoing presents the accomplishments of a full professional life. But what of Dr. Kane as we were privileged to know him? He possessed a high degree of native humor, a geniality, a tolerance, a warm-hearted love of all mankind which attracted to him a host of friends both in high and low places of society. He loved the pleasant things of life and was a jolly companion in any gathering. He was an enthusiastic sportsman but his favorite hobbies were fishing and photography. He had traveled widely with Mrs. Kane, particularly in the West Indies and South America. His domestic life was a happy one, and his lovely home, so well presided over by his wife, was a by-word for hospitality. There are many of us who will remember with warm affection our pleasant gatherings there.

Our profession has lost an extraordinarily able member. Many of us have lost a dear friend.

C. K. FRASER, M.D.
HOWARD P. PARKER, M.D.

EDITOR'S NOTE. The following letter was written to the President of the Society, Dr. William P. Herbst, by Dr. Herbert P. Ramsey, after the death of Dr. Howard F. Kane.

DEAR BILL:

Yesterday afternoon the light breeze was gently rustling the leaves in the trees of the little Court Street Cemetery in Machias, Maine, when our good friend

"Mickey" Kane was laid to rest in a quiet spot next to the graves of his parents.

At my side stood his brave wife, Clara, who, like him, had grown up in this typical northeastern Maine town. About stood their friends from near and far, as the Reverend William R. Riddiough, minister of the Center Street Congregational Church, pronounced the last words of interment.

As I gazed about, I thought that indeed these hardy Mainelanders are the salt of the earth, wresting their livelihood out of this rocky coast where it takes energy and enterprise to succeed.

In the brief moments we stood there it seemed as if all the experiences I had had with him passed in review. I thought of the service he had given our country in two wars, sweating out part of the first one in a German prison camp, and in the last one literally working his heart to death in a San Diego naval hospital.

There was the time and thought he had given to training students in obstetrics both at his alma mater, George Washington Medical School, and also at Howard University Medical School. I thought of the young men he had personally trained and successfully launched in the practise of obstetrics. His unfailing devotion both to his school and his "boys" came back to me.

I saw the faces of the thousands of women who could thank him for safe and more comfortable deliverance. I saw him a thousand times going out at any hour to answer the call of a brother physician in desperate need of assistance. He unceasingly sought also to raise the standards of practise.

I saw his unfailing good humor and thought of his many funny stories. I saw the enormous number who were proud to call him friend. I saw his enormous contribution to his time and knew we could never repay our debt of gratitude.

And then the service was over and we returned to the house. I thought then of the great and continuing sacrifice Clara had always made which enabled him to accomplish so much—sacrifice of that companionship which meant so much to her. I told her that I brought the love and sympathy of the Medical Society and the Medical School and the Surgeon General of the Navy.

She asked me to say how much the many expressions she had received meant to her, floods of letters and telegrams and the living room banked high to the ceiling with flowers telegraphed from everywhere.

Before midnight I was back here on the scene of his accomplishments—and I knew, Bill, how much you and I were going to miss him. Personally I have lost one of the finest and truest friends a man ever had. What more could I say? Except to add that we carry on and prove his expectations of us.

Cordially,

July 25, 1946 HERBERT

HOWARD FISHER, B.A., M.A., M.D.

(1866–1946)

Dr. Howard Fisher, a Life Member of the Medical Society of the District of Columbia, died July 8 at his home, 4849 North 30th Street, Arlington, Va.

Dr. Fisher was born in Wheeling, West Virginia, January 25, 1866. He received the literary degrees of B.A. and M.A. from Hanover College, the former in 1886 and the latter in 1889. He graduated from Jefferson Medical College, Philadelphia, with the Class of 1895, and became a resident of the District of Columbia in 1899.

En route to France to serve in an Anglo-French hospital during World War I, be survived the sinking of the ill-fated *S. S. Lusitania* in May, 1915. After the war he returned to Washington and joined the District Health Department, serving until his retirement in 1936.

Upon retirement he established residence in Arlington County, Va. At the outbreak of World War II he became a medical inspector for the Arlington County public schools.

Dr. Fisher became a member of the Medical Society of the District of Columbia in 1902. He was a Fellow of the American Medical Association.

Surviving is his wife, Mrs. Katharine C. Fisher, and a son, E. Boudinot Fisher, of East Norwalk, Conn.

GRANT SAMUEL BARNHART, M.D., F.A.C.P.

(1868–1946)

Dr. Grant S. Barnhart, an Active Member of the Medical Society of the District of Columbia, died July 25 at Doctors Hospital after a short illness. He resided at 1434 Rhode Island Avenue, N.W.

Born in Lock Haven, Pa., September 11, 1868, he came to Washington as a young man, receiving his medical degree from the old Columbian University in 1904. He had practiced continuously in the District of Columbia since that time. For many years he was a member of the staff of the old Washington Tubercular Dispensary.

Dr. Barnhart was elected to Active membership in the District Medical Society in 1908. He held fellowships in the American Medical Association and the American College of Physicians, was a Past President and Fellow of the Washington Medical and Surgical Society, and a charter member of both the George Washington University Medical Society and the Washington Civitan Club.

He was a 32nd degree Scottish Rite Mason and had held the highest office in a number of Masonic lodges. He was also very active in the Calvary Baptist Church. Other organizations with which he was affiliated were the Washington Board of Trade, Phi Sigma Kappa and the Congressional Country Club.

Dr. Barnhart is survived by his wife, Mrs. Bena A. Barnhart; a daughter, Mrs. Ruth D. Huff, Silver Spring; two sisters, Mrs. Alice Dories and Mrs. Lida Gottsdahl, both of Altoona, Pa.; and two brothers, John C. Barnhart, also of Altoona, and William E. Barnhart, Watervliet, N. Y., as well as four grandchildren.

JAMES FRANCIS O'DONNELL, A.B., B.S., M.D.

(1898–1946)

Dr. James Francis O'Donnell, an Active member of the Medical Society of the District of Columbia, died unexpectedly, July 22, at his home, 4302 East-West Highway, Bethesda, Md.

Dr. O'Donnell was born in Washington, D. C., January 19, 1898. He received his A.B. degree from St. John's College in 1915, and his medical training at Georgetown University, graduating in 1921. He also received his B.S. degree from Georgetown, in 1923. After interning at Georgetown Hospital, he spent a year as resident physician at Gallinger Municipal Hospital.

Recently he resigned his position as Associate Professor of Anatomy on the staff of Georgetown University School of Medicine, having been a member of the faculty for the past 20 years. On July 1 he retired from private practice. He had practiced medicine in the Bethesda-Chevy Chase area for 16 years. Early in 1946 he was appointed to the staff of Veterans Administration as a consulting physician. During World War I he was a member of the Students' Army Training Corps.

Dr. O'Donnell was a Fellow of the American Medical Association, an Active Member of the Medical Society of the District of Columbia since 1924, and a member of the Knights of Columbus.

He leaves his wife, Mrs. Gladys M. O'Donnell, and a daughter, Jane Frances; his parents, Mr. and Mrs. James Joseph O'Donnell; two brothers, Thomas B. and Dr. Dennis J. O'Donnell; and three sisters, Mrs. Katherine Burke, Mrs. Margaret Judge, and Miss Julia V. O'Donnell, all residing in Washington. A fourth sister, Mother Marie Joannice, a Catholic missionary, is stationed in China.

Neurology and Psychiatry—Katzenelbogen

(*Continued from page 419*)

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RECENT ADVANCES IN OPHTHALMOLOGY

BENJAMIN RONES, M.D.

Washington

THE present offers a good opportunity to pause and review the activity in all fields of medicine during the past few war years. This is necessary in ophthalmology, as in other medical specialties, for the research worker is again publishing the fruits of his activities, and the practitioner is beginning to have the leisure to digest them. This material will be reviewed in the categories of therapy, new disease concepts, and surgical advances.

THERAPY

Penicillin has been widely used in ophthalmology and its value in the therapy of ocular disease well defined. Lewis[1] used it in 30 cases of gonorrheal conjunctivitis and compared it with the results obtained in 173 cases treated with sulfonamides. With the penicillin there were no failures or recurrences, nor were any toxic or allergic reactions observed. The treatment was both systemic and local. If penicillin is not available, he recommends sulfadiazine as the drug of next choice. There was a dramatic reduction in the period of hospitalization from an average of 20 days by the old methods to 5.7 days with the use of sulfadiazine and 4.6 days with penicillin.

It was to be expected that an attempt to treat nonspecific uveitis with penicillin would be made. This was done by Irvine, Maury, Schultz, Thygeson, and Unsworth[2] in the treatment of Army Air Force personnel. They reported upon 56 cases of anterior and posterior nonspecific uveitis treated by penicillin intramuscularly and 8 additional cases of anterior uveitis treated by penicillin iontophoresis. Only in acute anterior uveitis (iridocyclitis) was significant improvement noted during or after the period of treatment. This improvement appeared no greater than would be expected with ordinary forms of treatment, such as atropine, heat, and foreign protein. These findings suggest that penicillin-sensitive bacteria are not ordinarily concerned in the etiology of nonspecific uveitis.

Leopold[3] found that intramuscular and intravenous administration failed to produce detectable amounts of penicillin in the vitreous in normal rabbit eyes. Subconjunctival and anterior chamber injections produced detectable concentrations. All methods of administration produced higher intravitreous concentrations of penicillin in inflamed eyes than in normal eyes. Intravenous injections of penicillin were ineffective against experimentally produced ectogenous infections of the vitreous. Subconjunctival and intravitreal injections, on the contrary, were effective.

Dunnington and von Sallmann[4] have carefully reviewed the literature on the use of penicillin and presented their own experimental work. They found that penicillin in high dilution is bacteriostatic against many species, especially the pyogenic cocci, gonococci, and clostridiums. It has a low tissue toxicity and great solubility and diffusibility. Infections of the lids, conjunctiva, cornea and lachrymal sac frequently responded well to penicillin after other therapy had failed. Early treatment is important. Ionization secured an effective amount of penicillin in the aqueous for four or more hours. The authors report 10 cases of severe intraocular infection treated with penicillin. Two cases of meningococcal endophthalmitis responded dramatically to penicillin by iontophoresis. They also had excellent results with one case of gonorrheal iritis, one of recurrent marginal ulcers, one of perforating injury, and several of delayed infection following operation. Their experiments showed that penicillin injected into the area of infection was more effective than iontophoresis. They also found that single injections of purified penicillin into the vitreous caused no toxic retinal reaction.

From Russia there comes an exciting report, which will drastically revise our prognosis in several eye diseases, if it should prove true. Filatov[5] used tissue extracts and tissue implants, as well as plant extracts and intramuscular injections of cod-liver oil, in various eye diseases. The tissues used were placenta, skin, liver, testis, and cornea from cadavers. Implantation was done subconjunctivally and subcutaneously. Extracts were used in the treatment of herpetic, rosacea, tuberculous, hypopyon, and interstitial keratitis; keratoconus; trachomatous pannus; uveitis; retinitis pigmentosa; high myopia; optic atrophy; and glaucoma. Good results were obtained in all types of cases. Filatov believes that the tissue and extracts act as biologic stimulators promoting the cells of the body to increased function and repair of damaged structures.

The above type of therapy is still to stand the test at the hands of other investigators. However, one cannot dismiss it lightly since such a reliable ophthalmologist as Filatov makes the report.

A debunking report of considerable significance has recently been sponsored by Woods[6] from the Wilmer Institute. This concerns the treatment of myopia by visual training, a method which has been given wide publicity by the optometric profession. The visual acuity without correction was recorded for each case in a series of 103 myopic individuals, a cycloplegic was instilled, and retinoscopic and static refractions were determined. The patients were then turned over to a group of optometrists and psychologists for a course of visual training designed to improve their uncorrected vision. In 30 patients (29 per cent) a low-grade improvement was noted. In 31 patients (30 per cent) no consistent improvement could be demonstrated, but an over-all improvement in both eyes was observed. The improvement in these two groups was not consistently maintained. In 32 patients (31 per cent) no change in percentage visual acuity could be demonstrated. In 10 patients (9 per cent) there was a decrease in percentage visual acuity. These changes in percentage visual acuity were within the limits of error of subjective testing of visual acuity. The author concluded that except for the improvement in interpreting blurred images and a beneficial psychologic reaction toward the handicap, there was no demonstrable value to visual training as a method of treatment for myopia.

NEW DISEASE CONCEPTS

There have been several new concepts in the field of ocular disease entities. Toxoplasmosis is a recently recognized infectious disease in human beings. Heath and Zuelzer[7] report upon it as a cause of eye disease. It is caused by a parasite, a protozoon of the genus toxoplasma.

In infants the central nervous system is especially susceptible to toxoplasma infection. In the active stage the spinal fluid shows an increase in protein content, pleocytosis and xanthochromia. Additional diagnostic evidence may be obtained by demonstration of the neutralizing antibodies against toxoplasma in the serum. The authors review the previously reported cases and add 2 of their own. The chorioretinitis is usually bilateral, and the lesions consist of multiple discrete, sharply bordered exudative or hemorrhagic areas. The age of the fundus lesion may be determined by the presence or absence of blood vessels and their relation to the lesions.

The ophthalmic and general medical journals have contained many reports recently upon the relationship of German measles (rubella) in a pregnant woman to congenital ocular and other defects in her offspring. This was first reported from Australia in 1941 by Gregg,[8] who found that in a series of 78 cases of congenital cataract, almost all the mothers gave a history of rubella in early pregnancy. In 44 of these cases a congenital heart lesion was also present. Following this a committee was appointed by the State of South Australia to investigate these findings. The panel consisted of an internist, a pediatrician, an ophthalmologist, and an otologist. Swan et al[9] reported their findings in the *Medical Journal of Australia* in September 1943. In this series there were 31 mothers who gave birth to children with congenital defects. Of these, all except 2 had contracted German measles during the first 2 months of pregnancy. Among the 31 babies with congenital abnormalities, there were 14 with eye defects, of whom 13 had cataracts and 1 buphthalmos. Nine of the babies had a cardiac lesion. Three seemed to be mentally deficient, and 1 had club feet. Seven of the babies were deaf. The authors concluded that if a woman contracts rubella in the first 2 months of pregnancy, her chances of giving birth to a congenitally defective baby are in the neighborhood of 100 per cent, while if she contracts rubella in the third month they are about 50 per cent. This important subject was first brought to the attention of the profession in the United States by Reese[10] and by Rones,[11] and their initial reports have been followed by many others. The relationship has been confirmed by all observers and has led to several important recommendations. It has been proposed that all girls be deliberately exposed to rubella in order to immunize them before the child-bearing age. There has also been the recommendation that convalescent serum be used for all women who are in early pregnancy and who have not had rubella, particularly during epidemics.

Ophthalmologists are plagued with inflammatory diseases of the uveal tract which resemble but do not fit into either the tuberculous or syphilitic categories. Diagnosis and treatment in these conditions has been very unsatisfactory. Krause[12] states that there are a large number of patients with unrecognizable brucellosis. This, together with the number with undiagnosed inflammatory ocular disease, would lead one to believe that ocular brucellosis is more common than is realized. He states that iridocyclitis, uveitis, and chorioretinitis are the usual ocular diseases accompanying brucellosis. The iridocyclitis is chronic and may be recurrent. The nodular form of iritis may predominate, or an exudative type may be present. The iritis may simulate a tuberculous or syphilitic disease. In the acute severe form neuroretinitis may be the only ocular lesion discovered. Harris [13] believes that the proper evaluation of the multiple available tests is important in obtaining a proper diagnosis of brucellosis, and he emphasizes the inaccuracy of the prevalent concept of the infallibility of the agglutination test. This test can be used in addition to the intradermal test, the opsonophagic test and isolation of the organism from various body fluids. Sulfadiazine and sulfathiazole have been of some value in acute cases. Transfusion of immune and non-immune blood, Foshay's antiserum, and fever therapy have also been used, but their curative value is doubtful. Penicillin experiments have not been encouraging. The author believes that the best results have been obtained with a vaccine of the abortus strain. Woods and Guyton[14] surveyed 200 cases of uveitis from the Wilmer Institute and found that the incidence of sarcoidosis would be about 2 or 3 per cent, while that of brucellosis would be a maximum of 7.5 per cent. The presumptive diagnosis of sarcoidosis depends on the clinical manifestations, cutaneous changes, pulmonary infiltration, rarefactions of the bones of the hands and feet, elevation of the serum globulin, and frequent anergy to tuberculin. The final diagnosis must depend on the demonstration of characteristic lesions in biopsy material of a lymph node.

The ocular manifestations of malnutrition was the basis of an excellent report by Ridley.[15] An examination was made of the eyes of 500 released Allied prisoners of war and internees from Thailand who claimed that their sight had deteriorated during captivity. Thousands had died from malnutrition and intercurrent disease. The food was inadequate in quantity, especially considering the heavy labor required, and was particularly deficient in protein, fats and vitamins. There were seen among these 100 cases of amblyopia with defective sight for from 2½ to 3 years. The onset had often been sudden, maximum disability being reached within a single day, but in others the onset was gradual over a period of months. Intercurrent infections tended to precipitate amblyopia, although in some cases an inverse effect was noted, since patients in the hospital received better food. Many of these patients had suffered from pellagra, edema of the legs, dry beriberi, and such minor lesions as sore tongue. A high percentage of the amblyopic also became nerve deaf. Campimetry revealed in 90 cases a small, sharply demarcated central scotoma. In addition to a full European diet, supplementary vitamins were administered. There was insufficient time to assess improvement, but after a fortnight about half the patients could see better. In some cases acuity improved by as much as 2 lines of the test chart, and in several the density of the scotoma was reduced.

Spies et al[16] reported on 300 patients who developed ocular disease after subsisting on diets deficient in riboflavin and who were treated for short periods with intravenous injections of riboflavin. Although it is unknown what specific ocular symptoms and lesions are caused by riboflavin deficiency, it is known that many such symptoms respond to riboflavin therapy. In the cases reported the patients had either subsisted on inadequate diets for many years, or in a few cases had eaten good diets until 1 year previous to the onset of the illness. A feeling of dryness in the eyes followed by burning and itching, sometimes by photophobia and lachrymation, were the initial visual symptoms. Congestion of the conjunctival vessels was common, with circumcorneal injection present in 80 per cent. In 53 per cent of the patients a corneal ulcer occurred in at least 1 eye. Subjective improvement occurred in all patients within 48 hours following administration of riboflavin, and there was a diminution in the caliber of the dilated conjunctival vessels and a decrease in photophobia and corneal ulceration. Many patients with irreparable eye damage were relieved of pain and their vision improved. Seventy-two per cent of the patients were able to return to work after months or years of idleness. Riboflavin therapy must be administered either orally or intravenously not only through acute manifestations, but until it is certain that the factors predisposing to riboflavin deficiency are eliminated.

SURGERY

The surgical advances in ophthalmology during the past few years have not been of a spectacular nature. Corneal transplantation has been undergoing modification of technic, and with more widespread usage has now become a fairly standardized operation, although still the subject of wondrous articles in the public press. The establishment of "Eye Banks" in New York and Chicago has overcome one of the most vexing problems of this type of surgery, and it is now possible to have corneal material available through these banks when needed. The eyes are enucleated at death, rushed to an eye bank by airplane, and kept refrigerated for several days. The material can then be sent to other cities as required.

Corneal transplantation may be inadvisable at times, either because of the excessive density of the scar or pronounced superficial vascularization. Castroviejo[17] described a method for removing corneal opacities by excision of the superficial lamella of the opaque cornea. This peeling or keratectomy is also advised instead of transplantation in some cases of superficial opacities of the pupillary area of the cornea and in cases of recurrent pterygium, pseudo-pterygium and symblepharon. Either a band-shaped (partial) keratectomy is done, or the entire surface of the cornea can be removed. In the case of a vascularized leucoma, as much as one half the corneal thickness may be excised.

Ophthalmologists have numerous operative procedures at their disposal for the lowering of the elevated intraocular tension in glaucoma. None of these operations has afforded deep satisfaction, as is evidenced by the recurrent reports in the literature. Practically all of these technics are aimed at increasing the area and rate of drainage of the aqueous by the formation of fistulizing channels or scars. Several attempts have been made to deal with the problem by diminishing the rate and amount of aqueous formation. Stocker has used the diathermy needle in a series of non-perforating punctures over the ciliary body. This cyclodiathermy operation was performed in 16 cases of non-operated chronic non-congestive glaucoma of various stages. Operation was indicated when the tension could not be kept within normal limits by miotics or when the visual fields and central vision showed evidence of deterioration. Serious complications did not develop in any case. The effect on the tension and the general course of the disease was beneficial. A prolonged lowering of the tension was obtained. Stocker[18] feels that cyclodiathermy puncture is effective regardless of the type of glaucoma, and that there is no danger of late infection or of cataract developing as a result of it.

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BENADRYL: A PRELIMINARY REPORT ON ITS USE IN 39 PATIENTS

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MANAGEMENT of the allergic state presents many difficult problems. Many times the use of epinephrine, ephedrine, aminophylline, and sedation is unsatisfactory, at other times even contraindicated. Preseasonal desensitization is often not successful nor is desensitization of value during the acute attack. Therefore, any new approach to this problem is of particular interest.

Benadryl (beta methylaminoethyl benzhydryl ether hydrochloride)* is capable of diminishing or abolishing some of the effects of histamine. Therefore, it has been suggested that such a histamine antagonist could be used in the treatment of conditions produced by the liberation of histamine or histamine-like substance.[1] The use of benadryl is believed by many[2-9] to be a logical and fundamental approach to the treatment of allergies.

RESULTS OF TREATMENT

This study was undertaken in order to evaluate the use of benadryl in 15 conditions, most of which are generally accepted as being allergic in origin. The drug was used in the other conditions not generally accepted as being allergic in origin because they presented similar symptomatology. Patients were treated in the private practice of one of us and at the Gallinger Municipal Hospital.

Table 1 summarizes the experience with 39 patients who were treated with benadryl. The total number of cases differs from the total number of patients because 2 patients are represented under 2 headings.

TABLE 1

Summary of Results of Use of Benadryl in 39 Cases

DIAGNOSIS	NO. OF PATIENTS	CHANGES IN CLINICAL CONDITION OBSERVED UNDER TREATMENT		
		Marked Relief (100-75%)	Moderate Relief (75-50%)	Slight or No Relief (49-0%)
Hay Fever	11	7	4	
Bronchial Asthma	8	1	3	4
Dermatoses				
Urticaria	6	5		1
Contact Dermatitis	2	2		
Neurodermatitis	2	2		
Chronic Eczema	1		1	
Sulfonamide Rash	1			1
Psoriasis	1		1	
Rash Associated with Infectious Mononucleosis	1	1		
Angioneurotic Edema	1		1	
Transfusion Reaction	1	1		
Ménière's Syndrome	1		1	
Cardiac Asthma	2	2		
Spastic Colon	2	2		
Penicillin Reaction	1	1		
	41	24	11	6

A. *Hay Fever.*—All 11 of our patients who had seasonal hay fever during the spring of 1946 and who were treated with benadryl experienced moderate or marked relief of acute symptoms in

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* Supplied through the courtesy of Dr. E. A. Sharp, Parke Davis & Co.

10 to 40 minutes after taking 50 mg. benadryl orally.

B. *Bronchial Asthma.*—Of 8 patients treated, 1 received marked relief, 3 received moderate relief, and 4 experienced no relief. The following is an illustrative case.

H. B., a 22-year-old white man, has had asthma since the age of 3 years, being sensitive to feathers, house dust and ragweed. He had been treated with routine treatments but still experienced moderately severe attacks. The episodes were usually preceded by upper respiratory infections, overexertion, or emotional stress. Each attack required several doses of adrenalin each day over periods of 3 to 10 days. The patient had 4 such attacks during the 3 months preceding institution of treatment with benadryl and hapamine in January 1946. During January and February the patient had 3 episodes of asthma, each lasting 1, 5 and 3 days respectively. During attacks the symptoms were entirely controlled by the use of 50 mg. benadryl every 4 to 6 hours. On January 29 desensitization with hapamine[2] was instituted. The patient has had no asthmatic symptoms since the last attack in February even though he has had several upper respiratory infections and has been under some emotional stress.

The 4 patients with bronchial asthma who did not respond to the use of benadryl presented similar histories and symptomatology. They were all chronic asthmatics with histories of repeated attacks. Benadryl afforded no relief immediately or when the dose was repeated in 1 hour's time. It was noted that 2 of these 4 patients became very drowsy after receiving benadryl and went to sleep. However, the physical findings in the chest did not change, and respiratory distress was still present. It is felt that the benadryl acted as a sedative in these cases and that no bronchial dilatation resulted. Other clinicians have also reported a higher percentage of failures in bronchial asthma than in other allergies.[3] Intravenous benadryl has been used on 3 occasions in a case of bronchial asthma without significant relief.[4]

C. *Dermatoses Not Including Urticaria.*—Eight patients with various skin diseases were treated. The pruritus present in every case could not be said to be on an allergic basis.

Two patients with contact dermatitis (poison ivy) were given 50 mg. benadryl, and in 10 to 30 minutes there was marked relief of the symptoms.

Two patients with neurodermatitis experienced marked relief from pruritus while receiving 50 mg. of this drug. Another patient with severe pruritus associated with chronic eczema, which appeared at times of emotional stress, experienced marked relief when treated with benadryl. This same patient also had hay fever which was controlled by the use of benadryl throughout the entire spring hay-fever season.

One patient with a pruritic sulfonamide rash was treated without improvement.

One patient with guttate psoriasis was able to sleep throughout the night following the administration of 50 mg. of benadryl which relieved the pruritus.

To our knowledge, the use of benadryl for the pruritus associated with the rash of infectious mononucleosis has not been reported previously.

B. L., a 24-year-old white woman, developed a generalized maculopapular rash with pruritus during the course of an illness which was diagnosed as infectious mononucleosis by the clinical course, blood studies and increasingly positive titers of heterophile antibody agglutinations. This rash improved without specific therapy until the patient was exposed to the sun. At this time the dermatitis became very pruritic, and treatment with 50 mg. of benadryl every 4 hours for 48 hours was instituted. In 20 minutes the pruritus disappeared, the relief lasting for a period of 3½ to 4 hours. Benadryl was continued in decreasing doses for 3 more days and then discontinued with no reappearance of pruritus.

One patient developed angioneurotic edema 15 minutes after taking a "666" cold tablet. He had swelling of the upper lip and face with difficulty in swallowing and a smothering sensation. Fifty mg. of benadryl gave marked subjective relief in 20 minutes with a decrease in the swelling at the same time.

D. *Urticaria.*—Six cases of urticaria were treated. Five patients experienced marked relief and 1 was not benefited.

Eight hours after eating a duck dinner, H. B., a 22-year-old white man, was awakened from sleep with an acute afebrile gastroenteritis with mild nausea and diarrhea associated with a generalized urticaria. He was given 100 mg. of benadryl, and the urticaria disappeared permanently. Three other people shared the meal and also had the gastroenteritis without urticaria. This case is of interest because the patient was the same one who received complete relief from severe asthmatic episodes with the use of benadryl.

One week after being given tetanus antitoxin, O. B., a 25-year-old colored woman, had swelling at the site of injection and generalized urticaria. She was given 50 mg. of benadryl with no relief of symptoms in 30 minutes. She was then given 10 c.c. of calcium gluconate intravenously with immediate relief.

E. *Prevention of Transfusion Reaction.*—The following case is unique.

The patient, E. W., a 67-year-old white man, was hospitalized in May, 1945, for treatment of a bleeding peptic ulcer. During hospitalization he was given 5 whole blood transfusions of compatible blood. Following each transfusion he had a severe chill, temperature elevation to 103° F., and generalized urticaria. In April, 1946, an operation was performed for a perforated appendix. During the early part of the patient's stormy course he was transfused twice with compatible whole blood. Each transfusion was followed by a severe chill, temperature elevation to 103° F., and urticaria. When it became necessary to transfuse the patient again, he was given 50 mg. of benadryl orally 20 minutes before the transfusion was started. The patient had no reaction following the transfusion. Several days later this procedure was repeated with a similar result.

To our knowledge, there has been no previous report of the use of benadryl prophylactically in the prevention of blood transfusion reactions. The use of benadryl in the prevention of urticarial reactions to infusions of plasma has been reported.[5] If this observation can be corroborated by further studies, it will be an important addition to the indications for using benadryl.

F. *Ménière's Syndrome.*—One case of Ménière's syndrome was treated with benadryl with some degree of improvement.

O. H., a 33-year-old white woman, presented herself with typical Ménière's syndrome accompanied by headaches that had many migraine features. The disease was of 2 weeks' duration, and there was no previous history of similar episodes. The patient was unable immediately to make arrangements for the daily intravenous histamine treatment prescribed. During the 2-day interval following the first visit she was given benadryl, 50 mg. every 6 hours, with marked relief of vertigo, nausea, and vomiting, but only slight decrease in the tinnitus and sensation of fullness in the ears. Following this the patient was given daily intravenous histamine as advocated by Horton[6] with complete relief of all symptoms after 1 week of treatment.

Previous reports[4,7] have confirmed the efficacy of benadryl in Ménière's syndrome with either marked or moderate improvement.

G. *Cardiac Asthma.*—Two patients, aged 72 and 84 respectively, who had persistent cough and asthmatic wheezes after all other symptoms of cardiac failure had responded to routine therapy, obtained marked relief from these residual symptoms with the use of benadryl.

The relief of symptoms in these 2 cases suggests that benadryl acted to reduce the bronchospasm that accompanied the cardiac asthma in these cases.

H. *Spastic Colon.*—Benadryl was used in 2 cases of spastic colon with marked relief of symptoms.

McGavack, Elias and Boyd[8] used benadryl on 7 patients with spastic colon with marked relief of symptoms in 3 cases and improvement in 4 cases. Of interest is their finding that there was a marked decrease in the amount of both free and combined gastric acid as a result of the administration of benadryl to subjects who showed free acid prior to the use of benadryl. Moreover, there was little or no rise in the gastric acidity after histamine injections while the patients were receiving the drug. This suggests that benadryl may be useful in the treatment of peptic ulcers and other conditions associated with gastric hyperacidity.

I. *Penicillin Reaction.*—One patient who developed acute urticaria following the administration of penicillin received marked relief following the administration of 50 mg. of benadryl. The successful use of benadryl has been previously reported in this condition.[4]

Toxic Effects

The most common side effects of benadryl are drowsiness, dizziness, dry mouth, nervousness and weakness. Other less common side effects that have been reported are fatigue, epigastric distress, irritability, dilated pupils accompanied by blurring of vision, nausea, and urinary frequency. There have been no serious side effects reported, and renal and liver function tests, blood counts and urinalyses have been done with no evidence of injury by benadryl.[8] In our patients we found drowsiness to be the most common side effect and this was usually effectively combated by using 2.5 to 5.0 mg. benzedrine sulfate (racemic amphetamine sulfate) in conjunction with the benadryl. In agreement with previous reports, it was found that benzedrine was usually no longer necessary after the drug had been given for a period varying from 2 days to 2 weeks.

McElin and Horton[4] have used intravenous benadryl as a therapeutic agent by the continuous drip method. Dosages of 10 to 120 mg. were given within a 10-minute period. They observed no evidence of acute toxicity and have observed only mild side reactions. The reactions found were the same as those following the oral use of the drug and were no more severe nor more frequent than when the drug was given orally. Oral doses up to 500 mg. daily have been given without ill effects.[8]

Discussion

Horton[4] stated that the common denominator of allergic disorders is the underlying problem of edema provoked by the local release of histamine or histamine-like substance. In the mucous membrane of the respiratory tract this edema is recognized as hay fever or vasomotor rhinitis. In the skin it appears as urticaria or angioneurotic edema; in the labyrinth, as Ménière's syndrome. If this conception of a common etiologic factor is a true one, then the use of antihistamine substances and desensitization with histamine in these conditions is consistent and physiologic.

It is felt that the use of benadryl has a sound physiologic basis, and it is suggested that there are possibly many fields of usefulness for this and related drugs that should be investigated further.

Summary

Thirty-nine patients were treated with benadryl. Most of the 15 conditions treated are admittedly allergic in nature and others are of doubtful etiology. The results in hay fever and urticaria were encouraging, whereas in bronchial asthma they were rather discouraging. In the miscellaneous conditions benadryl was successful in several instances.

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AVAILABLE ANTIBIOTIC PREPARATIONS AND THEIR TOXICITY*†

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PENICILLIN

ON July 6, 1945 the Federal Food, Drug and Cosmetic Act was amended to provide for the certification of batches of drugs composed wholly or partly of any kind of penicillin. The Federal Security Administrator, in accordance with the provisions of this amendment, has promulgated regulations providing such standards of identity, strength, quality and purity as will insure the safety and efficacy for use of a number of penicillin products. Before distribution in interstate commerce, each manufacturer must submit samples of each batch of any penicillin product to the Food and Drug Administration for examination and must obtain a certificate showing that the batch complies with the applicable regulations.

Sodium Penicillin and Calcium Penicillin.—Each of these drugs is so purified and dried that (1) its potency is not less than 500 units per milligram, (2) it is sterile, (3) it is nontoxic, (4) it is nonpyrogenic, and (5) its moisture content is not more than 2.5 per cent. Each batch of penicillin is tested for these requirements by the Food and Drug Administration.‡ Sodium or calcium penicillin may be packaged so that each container shall contain 100,000 units, 200,000 units, 500,000 units, 1,000,000 units or 5,000,000 units. The products should be stored in a refrigerator not above 15° C. or 59° F. The labeling for each package must contain clinical indications, dosage and administration, conditions under which solutions should be stored, contraindications and untoward effects that may accompany administration, including sensitization.

At the present time there are 15 primary producers of sodium or calcium penicillin. Listed alphabetically these are: Abbott Laboratories; Bristol Laboratories, Inc.; Commercial Solvents Corporation; Cutter Laboratories; Heyden Chemical Corporation; Hoffman-La Roche, Incorporated; Lederle Laboratories, Incorporated; Eli Lilly and Company; Merck & Company, Incorporated; Parke, Davis & Company; Chas. Pfizer & Company, Incorporated; Schenley Laboratories, Incorporated; E. R. Squibb & Sons; The Upjohn Company; and Wyeth Incorporated. All other firms which sell penicillin products in interstate commerce either purchase the material from the above firms and merely label it for distribution or they may transform the penicillin into one or more of the following forms:

Penicillin in Oil and Wax.—Penicillin in oil and wax is a suspension of calcium penicillin in a menstruum of refined peanut oil or sesame oil in which white wax is dispersed. Its potency is 100,000 units, 200,000 units or 300,000 units per c.c. Its content of white wax is not less than 3 per cent (W/V) if its potency is 100,000 units or 200,000 units per c.c., and not less than 4.7 or more than 4.9 per cent (W/V) if its potency is 300,000 units per c.c. Its moisture content is not more than 1.0 per cent and it is sterile. The calcium penicillin used has a potency not less than 750 units per milligram in the 100,000 unit or 200,000 unit strength and not less than 900 units per milligram in the 300,000 unit strength. The sesame oil and white wax conform to recognized standards. The labeling for this product bears information comparable to that for sodium penicillin and calcium penicillin.

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* From the Food and Drug Administration, Federal Security Agency.

† Presented at the Intensive Postgraduate Course, George Washington University School of Medicine, March 11, 1946.

‡ Federal Register, September 1, 1945.

At the present time several manufacturers are marketing the Romansky formula, which is 300,000 units of penicillin with white wax in peanut oil. Other firms are rapidly preparing to market this form of penicillin, since, of the various methods proposed, it appears to be the outstanding method of prolonging the action of this most valuable drug.

One manufacturer makes a product using sesame oil in place of peanut oil, with a penicillin concentration of either 100,000 units or 200,000 units per c.c. To administer the lower dosages one must use 8- and 12-hour intervals, respectively, as compared with the 24-hour interval usually used for the Romansky formula.

To facilitate the administration of this relatively viscous material Abbott has prepared a disposable plastic syringe which is used to administer 1 c.c. of this material from a cartridge. Bristol has prepared for experimental use a metal cartridge syringe with disposable or interchangeable needle which will probably soon be available for general distribution.

Oral Penicillin.—Oral penicillin is marketed as tablets of buffered penicillin and penicillin with aluminum hydroxide gel. Buffered penicillin tablets contain either sodium or calcium penicillin or both and one or more of the buffer substances, sodium citrate, citric acid, aluminum hydroxide, calcium carbonate, magnesium oxide and aluminum-dihydroxyamino acetate. The potency of each tablet is not less than 20,000 units; its moisture content is not more than 1.0 per cent and the sodium penicillin and calcium penicillin used conform to prescribed standards except that the potency is not less than 300 units per milligram. Each tablet of buffered penicillin may be enclosed in foil or plastic film, and the immediate container may also contain a desiccant separated from the tablets by a plug of cotton or other like material. The number of tablets in the immediate container is such that the total number of units therein is not less than 300,000. The labeling for buffered penicillin tablets contains the usual required information concerning storage, directions and precautions adequate for the use of such tablets by physicians. Such tablets are made by numerous manufacturers.

Capsules of penicillin in oil were prepared and distributed for a short time, but because of difficulties in manufacture the product has been recalled and is not on the market at the present time.

Penicillin with aluminum hydroxide gel is marketed in a combination package by one manufacturer. The package combination consists of a container of calcium penicillin or sodium penicillin and one of aluminum hydroxide gel. The potency of the penicillin is not less than 300 units per milligram and the aluminum hydroxide gel conforms to U.S.P. standards but contains not more than 50 viable microörganisms per c.c. The penicillin must be dispensed in a vial containing not less than 300,000 units and the aluminum hydroxide gel is dispensed in a quantity of 30 c.c. for each 100,000 units of penicillin. The labeling for this product must contain the usual required information concerning storage and indications and in addition the label for the penicillin must bear a statement "Warning—Not for injection" unless it contains penicillin which conforms to standards and packaging requirements for injectable penicillin.

Topical Penicillin.—Penicillin for local application is available in the form of a powder for surface application,* combined with a vasoconstrictor for instillation into the sinuses, and in ointment form for use in the eye and elsewhere. Other forms of topical penicillin are troches, masticatory troches and dental cones.

The penicillin for surface application consists of calcium penicillin and one or more of the diluents sodium chloride, milk sugar, sodium citrate and dextrose. Its content of viable microörganisms is not greater than is consistent with good pharmaceutical practice. The calcium penicillin conforms to prescribed standards and its potency is not less than 300 units per milligram. Each individual package contains not less than 10,000 units or more than 50,000 units of penicillin. The labeling contains the usual required information concerning expiration date, storage, indications and contraindications. In case the drug is not sterile the label will bear a statement, "Not sterile—not for injection—not to be used in deep wounds or body cavities."

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* Federal Register, March 2, 1946.

The penicillin ointment and ophthalmic ointment contain calcium penicillin in an ointment base composed of wool fat, petrolatum or white petrolatum, or any mixture of two or all of these, with or without liquid petrolatum, white wax, yellow wax, cottonseed oil, or peanut oil, oxycholesterin derivatives from wool fat, or any mixture of 2 or all of these. Its moisture content is not more than 1.0 per cent; its potency is not less than 250 units of penicillin per gram. Its content of viable microörganisms is not greater than is consistent with good pharmaceutical manufacturing practice. The calcium penicillin used conforms to standards mentioned above, except that its potency is not less than 300 units per milligram.

Penicillin ointment is packaged in collapsible tubes, not larger than $\frac{1}{8}$-ounce size if such ointment is represented for ophthalmic use and in no case larger than the 1-ounce size. The labeling for penicillin ointment contains the usual statements regarding storage in the refrigerator and also the statement, "Caution: To be dispensed only by or on the prescription of a physician," and a reference specifically identifying readily available medical publications containing directions and precautions (including contraindications and possible sensitization) adequate for the use of such ointment by physicians; or a reference to a brochure or other printed matter containing such directions and precautions and a statement that such brochure or printed matter will be sent to physicians on request.

Penicillin troches are troches composed of sodium penicillin or calcium penicillin or both in one or more suitable and harmless diluents, binders and lubricants, with or without one or more suitable and harmless masticatory substances, colorings and flavorings. The potency of each troche is not less than 500 units; the moisture content is not more than 1.0 per cent. The sodium penicillin and calcium penicillin conform to the standards prescribed above except that the potency is not less than 300 units per milligram. Like the tablets, the troches may be enclosed in foil or plastic film and the immediate container may also contain a desiccant. The labeling contains the usual statements regarding storage and expiration date as well as the statement, "Caution: To be dispensed only by or on the prescription of a physician." A reference to the medical literature or to a brochure must appear on the label as in the case of the ointment.

Penicillin dental cones are composed of calcium penicillin and one or more suitable and harmless diluents, binders and lubricants, with or without one or both of the sulfonamides, sulfanilamide and sulfathiazole. The potency of each cone is not less than 500 units; the moisture content is not more than 1.0 per cent; the content of viable microörganisms is not more than 50 per gram. If a sulfonamide is used its quantity is not less than 0.032 gram per cone. The calcium penicillin conforms to the standards prescribed except that its potency is not less than 300 units per milligram. The dental cones may be packaged in foil or plastic film and the container may also have a desiccant. The labeling contains the usual statements concerning the storage and expiration date, as well as the statement, "Caution: To be dispensed only by or on the prescription of a dentist or physician." The reference to medical literature or an available brochure must be made on the outside wrapper or container.

Penicillin Vehicles.—In recent months several vehicles have appeared on the market intended to be emulsified with penicillin with a view to obtaining slow absorption as occurs with penicillin in oil and wax. Since in the presence of water penicillin remains principally in the aqueous phase and is absorbed rapidly from this phase, it is not likely that these products based on a principle of emulsification will be successful.

STREPTOMYCIN

Streptomycin is available as the sulfate or hydrochloride and is prepared commercially by Abbott, Merck, Pfizer, and Squibb. Other firms are also making streptomycin on a small scale for research purposes. The sulfate is dispensed in vials containing the equivalent of 0.5 gram or 1.0 gram of streptomycin base. The hydrochloride is dispensed in vials containing the equivalent of 1.0 gram of the base. There is no legislation which provides for certification of streptomycin as with penicillin. The Food and Drug Administration has tested all streptomycin produced for the armed forces at their request. Temporary control is now exercised by the Civilian Production Administration under General Allocation Order M300 dated February 1, 1946. Since May 1 streptomycin has been available to civilians for certain specified uses through Dr. Chester S. Keefer, Evans Memorial Hospital, Boston, Massachusetts. Minimum specifications set up by the Food and Drug Administration for streptomycin* are as follows:

1. The minimum potency of commercial streptomycin shall represent not less than the equivalent of 200 micrograms of streptomycin base per milligram of dry powder. The potency of crystalline streptomycin base has been established at 1,000 micrograms per milligram.
2. It is sterile.
3. It is non-pyrogenic.
4. It is non-toxic.
5. Its moisture content is not more than 3 per cent.
6. It should cause no greater fall in blood pressure when injected intravenously into cats on the basis of 300 mcg./kg. than the equivalent of 0.1 mcg./kg. of histamine base.
7. It conforms to the bacterial spectrum (Waksman) produced by the streptomycin working standard.
8. It forms a clear solution with a pH of 6.0–7.5 when the dry streptomycin is reconstituted with sterile, pyrogen-free, distilled water in a concentration of 10,000 micrograms per milliliter.

TOXICITY OF PENICILLIN

Strictly speaking, the toxicity of drugs in the sense used by the pharmacologist refers to the relative amount necessary to kill a certain proportion of the animals in which the drug is being tested. In a broader sense and as used by physicians, toxicity includes any adverse reactions, allergic or otherwise, which occur as a result of the administration of a drug.

The toxic reactions due to penicillin were originally described by Keefer et al[1] as a result of its use in 500 cases as: fever, 5 cases; chills and fever, 12 cases; thrombophlebitis, 19 cases; urticaria, 14 cases; gluteal tenderness, 5 cases; headache and flushing, 10 cases; tingling in the testes, 2 cases; and pains in the muscles, 2 cases. Since that time most of these reactions have been explained on impurities, and as penicillin has become purer the only toxic symptom of any importance that remains is urticaria which now occurs in approximately 5 per cent or less of cases. Welch et al[2] showed a wide variation in the acute toxicity of commercial penicillin for mice but concluded that the toxicity was primarily due to the cation. Herwick et al[3] showed that pain on intramuscular injection was correlated with the amount of impurities present.

At the present time crystalline penicillin has been made available commercially by one firm and undoubtedly the others will soon be able to prepare it.* It does not require storage in a refrigerator, since its estimated stability, based on storage at 100° C., is approximately 67 years at room temperature. Except for allergy to penicillin itself there should be no toxicity from this crystalline product. Rostenberg and Welch[4] found that 5 per cent of 144 persons showed a tuberculin type of reaction to intradermal crystalline penicillin in spite of the fact that there was no previous history of contact with the drug.

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* "Minimum Specifications for Streptomycin—Standards of Identity, Strength, Quality and Purity," November 20, 1945, Food and Drug Administration. Effective July 15, 1946 Specification (1) reads 300 micrograms instead of 200 micrograms; Specification (7) reads "It shall contain no streptothricin"; Specification (8) reads "It forms a substantially clear solution with a pH of 5.0–7.0 when the dry streptomycin is reconstituted with sterile distilled water in a concentration of 50,000 micrograms per milliliter"; and Specification (9) reads "The expiration date of vials of streptomycin is eighteen months after the month during which the batch of streptomycin was released."

From September 1, 1943, when the Food and Administration began to examine penicillin for the armed forces, until July 6, 1945, when the certification amendment was passed, 4,709 samples of parenteral penicillin were tested and 308 or about 6 per cent of the total rejected. From July 6 to September 10, 1945, during which certification regulations were being drafted, 546 samples were tested and 14 rejected, or less than 3 per cent. Between September 11 and November 28, 1945, 911 samples were tested and 21 rejected, 2 of these being tablet samples, or less than 2.3 per cent. From September, 1945 to January, 1946, 1,162 samples were examined and 32 rejected, or about 2.6 per cent.

TOXICITY OF STREPTOMYCIN

Unlike penicillin, streptomycin is not inert from the toxicologic viewpoint; however, with the single exception of penicillin, there is probably no other chemotherapeutic agent of comparable activity which has a lower toxicity.

Early experiments revealed an LD_{50} of 800 micrograms (formerly units) intravenously and 5,000 micrograms subcutaneously for a 20 gram mouse. That these figures were affected by impurities was shown when pure streptomycin was injected in amounts of 650 milligrams per kilogram or 13 milligrams per 20 gram mouse. The acute and chronic toxicity of streptomycin is extremely low and there is little difference between the subcutaneous, intramuscular and intravenous toxicity provided that in the latter case the injection is made slowly. When given by mouth streptomycin is almost non-toxic, even in doses of several grams per kilogram, which is most likely due to the fact that only traces are absorbed from the gastrointestinal tract.

It has not been possible to correlate the acute toxicity for mice with undesired reactions in patients. These reactions consist chiefly of nausea, vomiting, headache, dizziness, fainting spells, rash, joint pains and delayed fever beginning 24 to 48 hours or longer after beginning treatment.

In all species of animals tested excessive doses of streptomycin have produced respiratory depression. Since this occurs after injection of the pure material it seems to be due to the drug itself rather than the impurities. The action appears to be one of direct paralysis of the respiratory center.

In addition to respiratory depression a second outstanding reaction produced by certain lots of streptomycin has been a histamine-like effect on the circulatory system. Severe reactions may occur with 0.5 gram or more in high concentrations, when given rapidly or in small volume. By diluting this quantity in 250 c.c. of water and injecting it slowly over 15 to 20 minutes the histamine-like effect can be completely prevented. In man the reaction has usually been transient, but it may constitute a danger in the presence of cardiovascular disease. Although this reaction is not related to the potency of the samples, pure streptomycin does not produce it, and accordingly we may assume that it is due to impurities.

Studies of chronic toxicity have been carried out on several species of animals prior to their prolonged use on man. Five dogs received dosages of 50 milligrams per kilogram subcutaneously or 100 milligrams per kilogram intramuscularly in 3 divided doses daily for 3 weeks. Within 10 to 14 days 1 dog on each dosage developed progressive amounts of protein, casts, epithelial cells and leukocytes in the urine. Serum protein was diminished and both dogs lost a good deal of weight. The remaining 3 dogs developed minor degrees of proteinuria.

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* Since this paper was given one other firm has already begun to distribute crystalline penicillin in commercial channels.

Monkeys were given 25 milligrams per kilogram intravenously or 50 milligrams per kilogram subcutaneously or intramuscularly daily for several days. Those which received 25 milligrams per kilogram daily showed occasional casts or blood cells in the urine, but kidney and liver function tests were normal. Fatty changes were seen in the liver and kidney after 10 days, but if the animals were allowed to live 30 days no such changes were found. Therefore, the changes are probably reversible. These effects were also produced by administration of pure streptomycin which assayed at 800 micrograms per milligram, and therefore are most likely not due to impurities. Monkeys who received several injections of 50 milligrams per kilogram or higher developed a transient anemia with increase of hemosiderin in the spleen, indicating that the anemia was hemolytic in type. Two monkeys who received 200 milligrams per kilogram for 5 to 10 days developed proteinuria which disappeared after stopping the drug. There was a transient increase of the blood urea nitrogen in some of these animals.

The chronic toxicity of streptomycin in man has been studied in patients with tuberculosis at the Mayo Clinic.[5] Twenty-two patients received 1 to 4 grams daily for 20 to 90 days. Repeated studies of the blood showed no significant toxic effect. Routine urinalysis, blood urea examinations, and urea clearance tests showed no toxic effects upon the kidneys in most cases. In 1 patient with a solitary kidney as much as 15 grams have been given over a period of 42 days without evidence of interference with renal function. However, another patient developed transient albuminuria and microscopic hematuria after 400 milligrams of streptomycin intravenously every 3 hours for 3 doses. There was no evidence of permanent renal damage in this case.

On the basis of serum bilirubin and prothrombin estimations, bromsulfalein and hippuric acid excretion on patients both with normal and slightly reduced liver function, no functional impairment of the liver could be demonstrated due to streptomycin.

Sudan IV stains of liver and kidney from a typhoid patient who had received 15 grams of streptomycin over a 4-day period revealed no fat.

Foshay[6] in using the drug on 7 patients with tularemia noticed that 1 developed somnolence. He interpreted this as being probably due to the disease.

Since testing streptomycin the Food and Drug Administration has rejected 2 out of 25 lots because they did not pass the histamine test, 4 out of 20 lots because of pyrogens, and 2 out of 21 lots for toxicity. One of the lots which was toxic was also pyrogenic.

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PENICILLIN THERAPY IN NEUROLOGY AND PSYCHIATRY[*][†]

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FOLLOWING intravenous or intramuscular injection McDermott and Nelson[1] were not able to detect more than minute amounts of penicillin in the cerebrospinal fluid. Schwemlein and others,[2] however, recently reported effective therapeutic levels in the spinal fluid after the intravenous injection of massive amounts of penicillin varying from 10,000,000 to 25,000,000 units. Intrathecal injection of small amounts of the drug was first reported by Rammelkamp and Keefer,[3] who observed signs of meningeal irritation and pronounced pleocytosis following this method of administration. Johnson and Walker[4] observed severe convulsive seizures following intraventricular injection of penicillin. These workers[5] also found that convulsive manifestations could be induced in animals by applying penicillin directly to the cerebral cortex. They were unable to separate the antibiotic agent from the convulsant factor in commercial penicillin. Upon further investigation they[6] found that pure crystalline penicillin produced similar results when applied to the cortex. When injected into the subarachnoid space penicillin does not usually reach sufficient concentration to produce convulsions. We[7] have been able to give daily intrathecal doses of 100,000 units each without ill effect.

In discussing the therapeutic results obtained with penicillin it is extremely important to bear in mind that in the past few years commercial penicillin has been a changing mixture of various substances.[8] It is better to say "penicillins," since fractions designated as G, F, K and X, which probably vary in molecular structure, have been identified. There is evidence[9] to indicate that the relative amounts of these fractions in commercial penicillin have varied from time to time, suggesting that therapeutic efficacy may not have remained constant.

The biochemical means by which penicillin exerts a bacteriostatic action on pathogenic bacteria is not understood. However, interesting observations have been made, both when it is used alone and in conjunction with sulfonamides. It has been reported[10] that sulfonamides potentiate the action of penicillin in vitro and in experimental animals. It has been further shown[11,12] that penicillin prevents the inhibiting action of para-aminobenzoic acid, present in exudates and normal tissues, upon the sulfonamide drugs. These observations suggest a well established clinical procedure of using both sulfonamide and penicillin in cases in which the response is poor to either one alone. One worker[12] suggests that the combined effect might be greater than a summation, possibly a potentiation, through the inhibiting action on para-aminobenzoic acid.

Other experiments[13] carried out on laboratory animals have definitely shown that the effect of penicillin on pathogenic bacteria lasts much longer than the measurable blood levels. Although blood levels persist for about 1 hour after the injection of penicillin, the depression of the bacterial population continues for 6 to 8 hours, or longer. The final clearance of streptococci from the body, which occurs many hours after the last injection, may be ascribed to normal defense mechanisms. This suggests that penicillin may continue its beneficial action in quantities lower than can presently be measured.

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[*] From the Medical and Surgical Department, St. Elizabeths Hospital.

[†] Presented at the Ninth Annual Meeting of the Medical Society of St. Elizabeths Hospital, April 26, 1946.

Recently, University of Chicago investigators[14] have demonstrated that penicillin has a neutralizing action on endotoxins prepared from meningococcal strains. They have shown that penicillin, repeatedly administered subcutaneously, is able to exert a considerable degree of protection against the lethal effects of meningococcal endotoxin. Probably in the future these findings will have clinical applications.

NEUROSYPHILIS

The application of penicillin to the treatment of neurosyphilis is of considerable interest to the psychiatrist. We wish to emphasize that only tentative statements can now be made regarding this. It will probably take a decade or more of careful observation before conclusions can be drawn. In general we believe that the value of penicillin in the treatment of neurosyphilis will prove not to be due to superiority of therapeutic results but to its low toxicity, thus allowing massive amounts to be given in relatively short periods of time. Penicillin also offers hope to those patients who would be unable to withstand fever therapy. With standard methods of treatment, syphilotherapy has of necessity been long and drawn out; with penicillin it may be possible to complete the active treatment period within a month. Thereafter, recheck examinations to determine the necessity of further treatment may be all that is required. Although the treponemicidal effect of penicillin has been demonstrated both in vivo (Mahoney[15]) and in vitro (Eagle[16]), the optimum time-dose relationships and methods of administration have not been worked out.

In the treatment of neurosyphilis the intramuscular route of administration has so far proved to be the most satisfactory. Intrathecal injections may be effective (Weickhardt[7]) but are probably unnecessary and may be hazardous. The main objection to the intravenous-drip technic has been the development of thrombophlebitis.

As to dosage, we have more or less arbitrarily employed a uniform dose of 25,000 units of penicillin intramuscularly every 3 hours until the desired total amount of the drug has been given. In this way severe Herxheimer reactions have in most instances been avoided. The total amount should probably be in the neighborhood of 4,000,000 to 6,000,000 units. Such a course may be repeated if necessary 1 or more times after 3 to 6 months. In general, patients who fail to show clinical or serologic improvement should be retreated at such intervals. The Dattner-Thomas[17] concept of activity of the neurosyphilitic process, i.e., increased protein content of the spinal fluid and pleocytosis, is frequently useful in selecting patients for retreatment.

One of the most important considerations which confronts the therapist is the problem of combining penicillin with other forms of antiluetic treatment. Eagle[16] has demonstrated that the treponemicidal effect of penicillin is greatly enhanced by elevation of body temperature. It would seem then that a combination of penicillin and fever therapy would be more effective than either alone. The work of the group of investigators from the Boston Psychopathic Hospital[18] would tend to substantiate this; but final opinion on this point must be reserved. Parenthetically, we may point out that penicillin and malarial therapy may be given simultaneously and are not incompatible. It has also been shown that there is a definite synergism in the action of penicillin and arsenic on the spirochete of syphilis (Eagle and others[19]). The application of this fact to the treatment of neurosyphilis has as yet hardly been tried.

Although it has few toxic effects, penicillin must not be regarded as an innocuous drug, especially in treating neurosyphilis. The possibility of a damaging reaction of the Jarisch-Herxheimer type must constantly be borne in mind. A relatively mild type of febrile reaction has frequently been seen following the first few doses of the drug. On the temperature chart this resembles a malarial paroxysm. The most serious Herxheimer effects take the form of convulsive seizures, status epilepticus, or cerebrovascular accidents.

Now to consider the effect of penicillin on the individual types of neurosyphilis. In asymptomatic neurosyphilis penicillin alone produces fairly prompt serologic improvement or reversal in the majority of cases (Stokes and others[20]).

In acute syphilitic meningitis the response to penicillin therapy is striking. Nelson and Duncan[21] reported 10 cases in which cranial nerve palsies cleared up; signs of meningeal irritation disappeared within a few days; and serologic reversal or improvement was rapid.

The value of penicillin in meningovascular syphilis is uncertain. Until more data are available we would suggest the use of standard treatment methods.

In syphilitic optic atrophy Bruetsch[22] believes that the use of penicillin alone is inadequate. He thinks that malarial therapy is still the treatment of choice in this form of neurosyphilis. However, he agrees that penicillin may enhance the value of fever therapy.

In tabes dorsalis Stokes and his co-workers[20] report instances of improvement or complete relief from tabetic pains following penicillin therapy but found such manifestations as Charcot joints definitely unaltered.

In the treatment of general paresis, the results following the use of penicillin are somewhat erratic. In our cases we feel inclined to agree with O'Leary[23] that in a few instances the clinical and serologic improvement is outstanding, but this outstanding improvement occurs infrequently and sometimes when least expected. In general the patients show a rapid drop in spinal fluid cell count and protein. Clinically the outstanding features are gain in weight, decrease of tremor, loss of apathy, and improvement of memory and intellectual functions. Several patients have been relieved of convulsive seizures; others have developed convulsions for the first time following completion of the course of treatment.

MENINGOCOCCAL MENINGITIS

For such reasons as differences in supportive treatment and strain variability of organisms one may say that there is no superior method of treating meningococcal meningitis. In October 1944 there was a report[24] of 9 cases of meningococcal meningitis treated unsatisfactorily with intrathecal and intramuscular penicillin. This supported the War Department's recommendation that sulfadiazine be the drug of choice. From the cases presented it was concluded that if good results were to be obtained from the penicillin treatment of meningococcal meningitis, one must suspect that the patient had received sulfonamides before entry. However, in August of the same year there appeared another report[25] of 31 cases with 30 recoveries which concluded that penicillin given both intrathecally and parenterally is safe, effective and highly potent in the therapy of meningococcal meningitis. Several workers[26, 27] have reported recoveries by use of the intramuscular or intravenous route. A recent report[28] on a study concerning the penetration of penicillin into the spinal fluid justly concludes that penicillin penetrates the meningeal barrier too erratically to justify its exclusive extrathecal use.

White and others[29] reported on 71 cases of acute purulent meningitis, stating that they could not specify an ideal regimen of therapy. However, they did formulate what they considered a safe, temporary plan of therapy with which we agree:

1. Prompt diagnosis and ample supportive therapy, including surgical intervention if indicated.

2. Two hundred thousand units of penicillin administered systemically each day by the continuous intravenous route, during the acute phase of the disease, and later by intermittent intramuscular injection, as the infection is brought under control.
3. Ten thousand to 20,000 units of penicillin into the subarachnoid space once or twice each day.
4. Ample sulfadiazine therapy given systemically to attain blood levels of over 15 mg. per cent of free drug with the penicillin.
5. Continuation of subarachnoid administration for 4 days after the spinal fluid has cleared and nuchal rigidity has diminished; and continuation of systemic penicillin therapy until 7 to 10 days after disappearance of all signs of infection.

The site of subarachnoid injection to be selected has not been settled. In many published reports the routes of administration have been combined, or altered, as the patient's condition changed. Nevertheless, White and others[29] state that the mortality in their series of patients, who received local therapy by the lumbar route alone, was 75 per cent, while the group of 15 patients who received some penicillin at a higher site of injection had a rate of less than 50 per cent. This suggests superiority of the intracisternal and intraventricular method of administration over the intraspinal route. There are mentioned 4 patients who had failed to improve with intraspinal therapy but responded promptly to intracisternal administration. All 4 recovered. Miller and others[30] report on a patient critically ill with meningococcal meningitis who proved resistant to the use of sulfadiazine and to intraspinal and intramuscular administration of penicillin. This patient responded following the drainage of fibrinopurulent material from the cisterna magna and the administration of 10,000 units of penicillin daily for 2 days into the cisterna magna. Harford and others[31] report a case treated by intravenous, intraspinal and intrathecal penicillin. The patient was a 30-year-old man who failed to respond in 48 hours to intensive sulfonamide therapy. He made a prompt recovery after the penicillin was started.

PNEUMOCOCCAL MENINGITIS

In pneumococcal meningitis the response to the use of penicillin, with or without sulfonamide therapy, is a more uncertain and diversified problem, both as to the age of the patient and to the source of the infection, which usually is an uncontrolled lesion in an air-containing cavity of the head. Waring and Smith[32] in 1944 reported on 12 patients with pneumococcal meningitis who were treated with sulfonamide and penicillin combined. Eight of the 12 were under 2 years of age; 1 was a child and the remainder were adults. Of the 12 patients 11 recovered and 1 died, the last shortly after admission. These workers stated that the results obtained were better than with the use of sulfonamides alone, or with penicillin alone. The patients received intraspinal penicillin in 5,000 to 10,000 units daily in divided dosage for 2 to 3 days and then half the amount daily. Older children and adults received 10,000 to 20,000 units intraspinally daily and 5,000 to 10,000 units every 3 hours intramuscularly. Younger children received proportionately smaller intramuscular doses.

Another study[31] of pneumococcal meningitis presents 9 patients with but 1 death, the last in the case of an infant that had not received penicillin until the twentieth day of the disease. Mastoidectomy, performed in 5 of the 9 cases, may have affected the recovery rate, which was about 50 per cent when a sulfonamide was used alone. Sweet and others[33] treated 16 patients with pneumococcal meningitis by penicillin, both with and without sulfonamides, with 9 deaths. Among 40 patients treated with sulfonamides and no penicillin there were 37 deaths. The 2 groups were shown to be similar regarding prognosis. They concluded that the optimal treatment of pneumococcal meningitis should include penicillin given both intrathecally and systemically, combined with sulfonamide therapy. Cairns and others[34] reached the same conclusion in another series of 16 cases with 12 recoveries, stating that, although sulfonamides are much less effective than penicillin, they are a valuable adjuvant in the treatment. A more recent report by Appelbaum and Nelson[35] declares that penicillin has not yet solved the precise method of treatment. In 67 consecutive patients, they obtained a recovery rate of only 39 per cent. They said that penicillin proved ineffective in the majority of cases. The difference in results may be attributable to the surgical inaccessibility of the primary focus in an older group, and to the differences in strain virulence. The latter represents a phase of clinical bacteriology which is likely to become increasingly important.

Streptococcal Meningitis

Since reports in the literature of cases of streptococcal meningitis are sparse, one has difficulty in illustrating the value of penicillin in its therapy. White and others[29] report 5 cases. Death occurred in 4. Of these 3 were moribund at the onset. In all of the fatal cases the patients received ample amounts of sulfonamides prior to the use of penicillin in the treatment of the primary foci; and all had received adequate intravenous and intrathecal penicillin therapy with no drug reactions. One had received 3 intraventricular instillations of the drug before death. In 3 of the 4 cases the spinal fluid had become sterile before penicillin was started. The single recovery occurred in a 3-month-old infant in whom the meningitis complicated a bilateral otitis media. Penicillin was started soon after admission, before the child had received any other form of therapy. She received 100,000 units daily by intramuscular injection, and 10,000 units were given intracisternally each day. Sulfadiazine was started on the fourth day because the fluid was cloudy, though sterile. It was continued 12 days after penicillin had been stopped. Also a bilateral myringotomy was done soon after admission. It is not possible to determine the respective role of penicillin, of sulfonamide, and of surgery in this recovery.

Another report[36] of 5 cases of streptococcal meningitis, 3 of which were produced by hemolytic organisms, and 2 by viridans type organisms, showed complete recovery with 10,000 units of intraspinal penicillin daily, for from 2 to 4 days. Supportive intravenous and intramuscular penicillin therapy was given for longer periods up to 8 days for control of complications. No sequelae occurred. The value of penicillin is more strongly indicated by these cases.

Staphylococcal Meningitis

In staphylococcal meningitis produced by hemolytic Staphylococcus aureus, penicillin has great effectiveness, as shown in reports by Evans[37] and White and others.[29] The method of treatment is not different basically from other forms of meningitis already mentioned. In most cases reported, sulfonamides had been administered before the use of penicillin, but progress was unsatisfactory. Another value of penicillin is its greater effectiveness in the control of dangerous staphylococcal bacteremia.

Hemophilus Influenzae Meningitis

There is a report[38] in the Uruguayan literature of 3 cases of H. influenzae meningitis successfully treated with sulfonamide and penicillin. Extremely large doses of sulfathiazole were used along with intraspinal penicillin. The infants were treated for from 39 to 50 days with frequent relapses.

Cavernous Sinus Thrombosis

The treatment of cavernous sinus thrombosis, a long dreaded and dangerous complication of infections of the head, was given new hope with the introduction of the sulfonamides. Heparin plus sulfonamide further increased the survival in this disease. Goodhill[39] reported a case in which no response followed the use of heparin and sulfathiazole. Yet a prompt clinical response followed intravenous penicillin. Johnstone[40] presented a similar case and concluded that penicillin probably was the drug of choice. Another report by White[41] tells of a dramatic response to intramuscular penicillin only in a year-old child. Cures are reported with the use of heparin and penicillin by both Wiesenfeld[42] and Henner.[43] In all cases the disappearance of marked neurologic eye signs was nearly complete. The etiologic organism in these cases was hemolytic Staphylococcus aureus.

Brain Abscess

The advent of penicillin in the treatment of brain abscess has not changed the precept of incision and drainage. Then too, it is a fairly well settled matter among neurosurgeons that surgery for a brain abscess during the acute stage of spreading encephalitis is likely to prove a disastrous procedure. There is usually a period of supportive treatment and waiting for localization of the abscess. Furlow[44] presents a case which indicates that penicillin may be an effective agent preventing rapid spread and maintaining localization of the abscess. A stubborn case of brain abscess with left hemiplegia is recorded by Walker,[45] who gave intramuscular penicillin uninterruptedly for 41 days. Pus was drained from multiple intracranial abscesses by 7 operations in 26 days. During his illness the patient lapsed into coma and became hemiplegic on 3 separate occasions. On each of these occasions surgical drainage resulted in a prompt return of consciousness and recovery from the hemiplegia. His final recovery was complete and lasting. Two interesting observations were made, one that immediately following the surgical drainage of the active source the temperature dropped to normal and remained so throughout the illness, the other that there was localization and absence of gross inflammation usually present in infected wounds.

Traumatic Neurosurgery

The applications of penicillin therapy in traumatic neurosurgery are as diverse as they are valuable. An article by Cairns[46] on head and spinal wounds recommends the prophylactic use of intramuscular or intrathecal penicillin for contaminated or infected wounds having close relation with the subarachnoid space. The author points out that it is necessary to drain abcesses when present and that the removal of foreign bodies, dirt, hair, bone chips, and pulped brain is essential.

Tetanus

In the last year or two there have been several reports[47, 48] suggesting the value of penicillin in the treatment of tetanus. However, the evidence goes no further than the suggestion of value. An article[47] based on but 2 cases concludes, "In view of the high mortality of tetanus, even when treated with large doses of tetanus antitoxin, the addition of penicillin is apparently a life-saving measure." Most authorities agree that after a fatal dose of toxin has become fixed in the central nervous system death is inevitable. Although penicillin has a bacteriostatic effect on Clostridium tetani, it has no effect on its toxin. It may be supposed that possibly the antitoxic action of penicillin may be acting, or that the usual symbiotic association with aerobes is destroyed, thus precluding the survival of this obligate anaerobe. Although the issue is not settled, the best evidence seems to be a review of 16 cases by Altemeier,[49] who was unable to show any beneficial effect of penicillin in the disease proper.

Conclusions

1. If penicillin is used in the treatment of neurosyphilis, the following suggestions are made:

   a. Use the intramuscular method of administration.

   b. Give at least 4,000,000 units, preferably 25,000 units every 3 hours. Repeated courses may be necessary.

c. In the asymptomatic, acute meningeal, and tabetic forms penicillin alone may be used.

d. In general paresis and primary optic atrophy combine penicillin with a full course of fever therapy. Use penicillin alone only if fever is contraindicated.

e. Adequate follow-up examinations are essential in all cases.

2. Penicillin is a valuable agent in the treatment of many acute purulent infections of the nervous system. There may be frequent abuses of its proper application by indiscriminate use and disregard for its pharmacologic properties. Penicillin does not supplant the sulfonamides, and their combination may be most effective.

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Editorials

THE HEALTH OF INDUSTRIAL WORKERS*

Every industrial plant employs a man or crew of men whose job it is to lubricate, adjust, repair and tune up plant machines, that they may be kept at their peak of productive capacity. That is just good business. Isn't it equally good business for the employer to provide for the adjustment and repair and "lubrication" of the human machines upon which the operation of the steel machines depends?

Employers are gradually realizing the importance of providing, through an organized service, for the health of those who are responsible for production and seeing to it that physical and mental illnesses are given prompt attention. Of importance, too, are wholesome working conditions, protection against hazardous processes, and health education programs which bring home to workers the simple principles of healthful living.

Practically all of the very largest industries and stores employ professional staffs—physicians, nurses, sanitary engineers and technicians—for maintaining the health of employees. And they consider it a good investment.

Thousands of other large plants make similar provision. But there is a great industrial area almost untouched. Seventy-two per cent of industrial workers in the United States are in plants employing less than five hundred. Very few of these plants have anything more than a physician on call for emergencies, and that certainly is not an industrial health service, except in embryo. Adequate service means preplacement and periodic physical examinations; supervision of "plant housekeeping"—light, ventilation, temperature, humidity, cleanliness, sanitary facilities; control of toxic substances, air content, and hazardous processes; emergency service for illness and accident, and reference to the private physician for continuing treatment, with follow-up of illness absenteeism and health education. Constant emphasis, of course, must be placed on preventive measures.

Few small industries, by themselves, can undertake any such program. But in several cities groups of these industries have combined in a coöperative plan and have set up a joint unit with medical, nursing and technical service and central dispensary facilities. This plan makes available to small industries a health service comparable to that of single large plants. It is reasonable to hope that such coöperative plans may be extended to many small plants and eventually, perhaps, to offices and stores.

The industrial manager is coming more and more to recognize his moral responsibility for the welfare, the health and the happiness of those men and women whose working life is largely under his control. But industry seeks to keep as many men working at as many machines as many days as possible and so the small as well as the large industrialist must be shown the value of health service in reducing absenteeism, in increasing the efficiency of the man on the job, and in the expanded production which can and does result.

There is a challenging opportunity in this field for the physician who is willing to equip himself for industrial service.

Howard Strong
Secretary, Health Advisory
Council, United States
Chamber of Commerce

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* This is the eighth in a series of guest editorials by distinguished physicians and laymen. Others to follow will deal with the scientific, social and economic aspects of medicine.

SOME ADVANCES IN PREVENTIVE MEDICINE AMONG CHILDREN

The marked increase in life expectancy during this century is not alone to be attributed to better health in an aging population but also to the lessening of disease among the young, which has contributed a large share in prolonging the span of life.

A brief account of some of the advances of preventive medicine as applied to infants and children not only indicates the success of such measures but may be utilized by physicians as propaganda to further the more universal adoption of prophylaxis in childhood, which as yet falls far short of the goal of complete accomplishment. At the same time, generous acknowledgment should be made of the acceptance by the public, and especially by mothers, of the desirability of prevention rather than cure of disease as affecting their offspring.

The occurrence of gastrointestinal disorders in early childhood has been tremendously lessened by attention to the question of purity and sterility of foods, especially during early infancy. Contributing to the cause of preventive medicine has been the almost universal use of sterile processed foods, evaporated and powdered milks, vacuum-cooked vegetables and cereals an accomplishment which ensures purity and in most instances avoids deleterious destruction of vitamin content either by modern methods of processing or by the addition of vitamins which might be destroyed in the process of manufacture.

It may now be said that pediatricians no longer fear "summer complaint" but "winter complaint," which has largely replaced the seasonal curve of infant sickness so long held by the former.

Any illness among the young which is associated with loss of body fluids and important electrolytes with consequent dehydration is now an indication for early administration of fluids containing needed salts and blood constituents, such as saline, glucose, sodium bicarbonate or its more advantageous substitute, mono-lactate of soda as developed by Hartmann, amino-acids, and more recently the inclusion of potassium salts as advocated by Darrow. Serious outcome of infantile disease may thus be prevented in many instances by early adoption of such methods. Parenteral fluid "foods" have quite largely replaced feeding by mouth in the acute stages of illness, anorexia, lethargy and stupor of sick infants contributing to such a substitution.

Measures granting more or less permanent immunity, as well as those securing transient, passive protection against the communicable diseases of childhood, have had increasingly favorable results, reflecting a betterment in the morbidity and mortality rates of afflictions hitherto resulting in considerable loss of life among the young. Most significant is the widespread use of immunization against diphtheria, which approaches 100 per cent of successful "takes." The certainty of success in this respect may be easily demonstrated by the use of the simple Schick test, readily applied and easily interpreted. During the past few years diphtheria mortality has fallen to a new low as shown by a statistical study made by Dr. C. C. Dauer, epidemiologist of the D. C. Health Department, which reveals the following: Diphtheria cases reported in 1935 were 963 as against 18 in 1945. In 1942, cases reported numbered 67 with 2 deaths; in 1943, 27 cases with 1 death; 1944, 9 cases with no deaths; 1945, 18 cases and no deaths.

Smallpox vaccination as a compulsory measure in primary and preparatory schools, and as a requisite of admission to colleges, as well as an elective procedure now insisted upon by the great majority of parents of young children, has resulted in building an immune population which an invasion of smallpox would find an infertile field.

The same mass immunity in childhood, especially favored by schools and camps, against typhoid fever, whooping cough, tetanus, and Rocky Mountain Fever in infected areas, has been largely secured through the use of vaccination against these infections peculiarly apt to affect the young. The advantage of "booster" or "stimulating" inoculations is now widely recognized by the laity as well as by physicians intent upon prophylaxis.

Immediate, although passive immunity to measles has been secured by the use of the newly developed gamma globulin fraction of the blood made available as a by-product of processing centers preparing blood itself or its component principles for the use of the armed forces. Either complete protection against measles or modification of the disease has been made possible by suitable timing of injections and regulation of the dosage.

Protection against whooping cough, while not obtained in such a high proportion of subjects as that of diphtheria immunization, warrants its more universal use. Passive immunity to whooping-cough may be granted "exposees" by the prompt use of hyper-immune human serum now available from several reliable sources and of demonstrable worth as a highly successful preventive agent in infancy and early childhood.

There must be mentioned, also, the widespread use of tuberculin testing, either through the use of O.T. or P.P.D. tuberculin, or by the easily applied patch test, in determining not only the presence of tuberculosis, healed or active, but with confirmatory X-ray findings, constituting preventive measures of vast import to the child, the family, and the school. More recently, as applied to the pregnant mother, it may mean the prevention of postnatal infection in her offspring.

Of quite recent development are preventive methods relating to the welfare of the infant, prenatally and upon delivery, incident to the mating of parents with incompatible Rh factors. Prevention of disaster to the infant has been given intensive study of late, and prophylactic measures may fall into several categories. The testing of every pregnant mother as to her Rh component, and with the approach of term, the accurate estimation of the presence and titer of the anti-Rh agglutinins in her circulating blood, should be regularly and routinely employed. Many obstetricians feel that, with a mounting anti-Rh agglutinin titer, the induction of premature labor at a period consistent with the likelihood of infant survival against the hazards of prematurity offers the best chance to the offspring. The recognition of the possibility and even the probability of an erythroblastotic infant, aside from the obstetrical procedure just noted, warrants the adoption of every preparation for instant treatment should hydrops, icterus, profound anemia or other signs confirmed by blood studies reveal the presence of erythroblastosis. Rh negative blood should be immediately available for instant transfusions, and hospitalization, if not already accorded the mother, must be immediately granted the infant.

In order to avoid sensitization of the female child by one or more transfusions of Rh positive blood, which might precipitate at a later period of married life the hazard of erythroblastosis in her infant, the Children's Hospital of Washington now determines the Rh factor in all girl children receiving transfusions in order to ensure the use of blood of the proper Rh reaction.

Limitations of space permit but a passing mention, which is entirely inadequate considering the importance of the subject, of the vast import of preventive measures in the detection and treatment of psychological problems in the young. Our city is woefully lacking in facilities for study and treatment of disorders in the mental health of young children.

Lastly should be emphasized the mounting toll of accidents to children, which in congested cities now constitutes one of the largest causes in the loss of child life. Accidents do not really just happen; they also may be classed as falling within the scope of prevention which must be sought through education of the child as well as of the driver of that modern instrument of death, the automobile.

J. S. W.

"IT CAN'T HAPPEN HERE!"

The care of the mentally ill has from the beginning been considered a proper function of the state. Some states, to be sure, have discharged this responsibility poorly; appropriations have been niggardly; and partisan politics has not infrequently outweighed the welfare of the patients. The average has been none too high, and only a few states have been outstanding. There are those who have cried aloud for Federal aid and control, on the assumption that the Federal government is possessed not only of greater funds but of greater wisdom and a greater willingness to utilize medical advice on medical problems. Is the latter assumption valid? Recent developments in Washington warrant skepticism.

Saint Elizabeths Hospital, established by Dorothea Lynde Dix in 1855 for the care of the Army and Navy, has long been recognized as a leader. Its standards of care have been high, and its civilian atmosphere has been an advantage in dealing with military patients, being reflected in a high recovery rate. During World War II over 5,600 Naval personnel passed through it as patients, a large majority being discharged as recovered.

In the spring of 1945, the powerful Bureau of the Budget, as represented by one of its lesser luminaries, concluded, without medical advice or without consultation with either the Navy or the Hospital, that the institution should be reduced in size; the simplest way, it concluded, was to stop Naval admissions and have the ex-service patients removed. Letters were prepared for the President's signature, and signed and dispatched, instructing the Navy to send its patients elsewhere and directing the Federal Security Agency to arrange with the Veterans' Administration to have eligible servicemen removed to veterans' hospitals.

In a press interview shortly therafter, the Director of the Budget is reported to have said, "We simply feel on the basis of what we know about the development of mental hospitals in this country that Saint Elizabeths cannot continue to increase indefinitely, and we feel it's plenty large enough." Asked where the Navy should care for its psychotics, he replied, "We weren't concerned about that." Whether the Navy load would fall as the the fighting ceased, whether the Naval patients would be as well or conveniently cared for, whether the radical change would be good or bad for the Hospital—these considerations were of no moment. The budgeteers know all! Eminent experts called in by the Navy and by the Federal Security Agency advised against a change in policy, but the Budget decisions are like the laws of the Medes and Persians.

The step which might have been reversed so long as it remained a Presidential "directive" was made more nearly irrevocable when the President embodied the change in Reorganization Plan Number Three on May 16. The American Psychiatric Association, through its Council, officially opposed the change, and Drs. Whitehorn and Chapman presented to the Committees of the House and Senate strong reasons why the legislation should not be enacted. The House, indeed, thanks largely to a physician member, Dr. Walter Judd of Minneapolis, overwhelmingly voted down the proposal, but the Senate, despite Senator Ferguson's strong opposition, passed the Plan by a margin of only seven votes. As the veto of both houses was necessary to prevent passage, the Plan became law. The Navy will hereafter use the Public Health Service Hospital at Fort Worth, Texas, reimbursing the Public Health Service at a rate slightly more than twice the 1946 per capita rate at Saint Elizabeths Hospital.

It *can* happen here!

MEDICAL CARE OF VETERANS

In the year following the cessation of hostilities of World War II, the number of veterans on the rolls of the Veterans Administration has increased to the amazing number of 17,499,000. Of this number, 13,538,000 are veterans of World War II. The task of providing medical care for this enormous number of potential patients was thrust upon the medical department of the Veterans Administration long before it was expected because of the sudden collapse of the Japanese front.

Although at first it seemed that long delay confronted any veteran seeking help, mighty efforts on the part of General Omar N. Bradley and the Director of his Medical Department, Major General Paul R. Hawley, in cutting red tape and efficiently organizing the available medical facilities, have resulted at the end of the first year in a picture which must have been disappointing to the pessimists. One of the important cogs in this efficient machine has been the functioning of the various Deans' Committees. The local Dean's Committee, with its very able Chairman, Dr. Walter Bloedorn, by reorganizing the staff of Mt. Alto Hospital, has been able to increase the turnover in that Hospital from .89 in April of 1946 to 1.71 in August of 1946.

Outpatient departments in the District of Columbia under the auspices of the Veterans Administration have begun to function smoothly and as of July 1, 1946, had cared for 2,739 individuals. This load is naturally expected to increase, and plans are being made to provide the extra care necessary. A committee of the Medical Society has met several times with representatives of the Veterans Administration to work out a fee schedule for the out-patient care of veterans. At the present time this plan contemplates taking care only of veterans with service-connected disabilities who are unable to gain admission in an emergency to a Veterans Bureau facility. This plan has been approved by the Executive Board and will soon be submitted to the membership for its approval. Although very limited in the scope at the present time, it is capable of unlimited expansion, should such a necessity arise. It is interesting to note that the first such plan submitted to the Veterans Administration was that of the Medical Society of the District of Columbia, and it is equally interesting to note that it was the last to be approved. The need for such a plan is much greater in rural and suburban areas where no Veterans Bureau facilities are within easy access of the sick veteran. The lack of a local need for a plan is evidenced by the fact that on July 1 of this year there were only 272 veterans awaiting hospitalization in this area and none of these had service-connected disabilities.

New services are constantly being added by those responsible for the medical care of the veterans and much waiting has been eliminated. The newest addition to the complete medical coverage which the Veterans Administration is authorized to provide for veterans is the provision of pharmacies where prescriptions may be filled at Government expense.

The Veterans Administration is to be congratulated upon its accomplishments during the first year since V-J day with such limited physical equipment. With the establishment of its new hospital, the site of which we hope may be selected soon, the local veteran may congratulate himself on the excellent medical care provided for him.

John R. Cavanagh, M. D.

In and Out of Focus

BY THE OBSERVER

Co-op Plans Urged

Thanks to those responsible for its publicity, the National Conference on Coöperative Health Plans, held at Two Harbors, Minnesota, the middle of August, attracted nation-wide attention. Despite the fact that the Conference was held in a small Midwestern town, some two hundred delegates and visitors from fifteen states, Hawaii, and two Canadian provinces were in attendance.

The Conference was addressed by physicians and laymen, some of whom were ardent advocates of a government system of medicine. The majority, however, were favorable to coöperative medical plans as a solution for deficiencies in the distribution of medical service.

One of the most active participants was Mr. Harry Becker, President of Group Health Association, Inc., of Washington. Intelligent and energetic, Mr. Becker endeavored to place the Conference on record in favor of President Truman's health program. He finally obtained the adoption of a resolution "with specific safeguards designed to remove fears of the effect of a national health bill on the voluntary movement."

On the last day, the Conference approved a constitution for a national federation of voluntary medical service plans, which, according to the *New York Times*, would have "effective consumer control in matters pertaining to policy." The federation, to be known as the Coöperative Health Federation of America, is to be incorporated in the District of Columbia and, according to reports, will engage in public education, formulation of legislation and technical assistance to groups interested in furnishing prepaid consumer-controlled medical care on a non-profit basis. Headquarters of the new Federation has not been decided upon. Membership qualifications, in addition to consumer control, are that participating organizations must be non-profit and maintain satisfactory quality of service. Associate membership is provided for public, private, or non-profit groups interested in the Federation's objectives. Medical plans sponsored by medical societies are not eligible because consumers are not represented in their management.

The resolution introduced by Mr. Becker and approved by the Conference placed it on record as endorsing "the principle of public responsibility for assuring the availability of health and medical service for all the people without economic or other barriers," and endorsing "larger grants to states for public health purposes and nation-wide health insurance under public auspices." As a condition to the Conference's support of a national health program, the following assurances were given, "No state may participate which legally or otherwise restricts free development of consumer-sponsored medical service plans, and there must be a majority or equal representation from organized consumer groups on an administrative and policy-making body of the national plan at all levels."

As was to be expected, the *Journal of the American Medical Association* commented on the "Co-op" meeting editorially. Here is what the *Journal* for August 31 had to say:

> "For the most part, those who attended the Conference appeared to be ardent, sincere, crusading advocates of rapid and all-inclusive changes in the medical world. They want to change the Principles of Medical Ethics; they want to change medical education; they want to change the present methods of medical practice. The patient-physician relationship, they insist, is a mere fetish; they want to change state laws; they want to outlaw many states in which medical service plans developed by county and state medical societies have legal recognition. They advocate that the coöperatives themselves enter the manufacturing of surgical and medical supplies. They want to change the balance of influence so that the

> doctors will become technicians rather than leaders in the medical care program. They want to bring the world under consumer control. In short, they want to change the very concept of most Americans as to the American way of life 'even by compulsion.'
>
> "This catalogue of a revolutionary platform should cause physicians considerable concern. Here was an orchestra of virtuosos with each of the players trying to lead in a different beat of the time. Amidst the cacophony came occasionally a theme of hate for the American Medical Association. And while for a moment they seemed united in approving a program of conduct, each will be found sounding his own particular tune at the next concert."

Your Observer agrees that the Conference's "platform" should cause physicians "considerable concern." However, in his opinion, it is another instance of the AMA being unnecessarily placed in an unenviable position. Virtually nothing has appeared in the press to convince the public of the fact that the AMA is making progress with its prepayment plans. This is disappointing to many physicians who hoped that following the action of the House of Delegates approving the development of a national health program much would be accomplished, and that fairly soon.

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"All They Ever Give You Is Aspirin"

Veterans of World War I will recall the often repeated saying, "Paint 'em with iodine and mark 'em duty." It undoubtedly reflected, to some degree, their opinion of the medical service which they received.

Whatever criticism might be justly leveled against the service then given, it was undoubtedly the best that any army had received up to that time. Good as it was in comparison with what had been provided before, it was far from being what the G.I. received in World War II. For the medical service in all branches of the armed forces was vastly improved. In fact, it was, by all odds, the best medical care ever provided a large body of men. Nevertheless, there were deficiencies which are perhaps inherent in any regimented form of medicine.

To ascertain what the G.I. really thought of the medical care he received, Major George S. Goldman, M.C., A.U.S., selected "an intelligent and technically proficient enlisted man" to assist in his clinic. The officer questioned his new assistant about his experiences as a trainee. These are reported in an article entitled, "The Psychology of Sick Call," appearing in the July 1946 issue of the *Bulletin of the U. S. Army Medical Department.*

In response to interrogation, the enlisted man said:

> "You doctors by your own admission say that there is very little real malingering in the Army. The soldier who goes on sick call really believes he is ill. He can't understand why he gets nothing more than a grade A sneer from the doctor and a back-to-duty order. He gets mad. He tells his squad. The squad gets mad. The squad tells the platoon. The whole damn platoon is angry over an alleged injustice to one of its members who they all believe had the physical ailment and was entitled to treatment. This resentment takes the form of disinterest in instruction, minor insubordination, and low morale. The soldier felt he was really ill. He doesn't want to be told he is a gold brick when he honestly feels he isn't. Five seconds on the doctor's part, a smile instead of a sneer, a little comforting advice, and perhaps some medication can avert trouble for the whole platoon. Soldiers and medical officers cannot be over-instructed on how to go on sick call and what to expect and why to expect it. Nothing so stirred up my platoon as a whole as a slight to what we considered a sick companion-in-arms.
>
> "At my induction here at the camp we were bombarded with solemn warnings to see the doctor whenever we felt ill. Some poor naïve babes in the woods took this seriously and found to their chagrin that it was just advertising. The platoon corporal, the platoon sergeant, the first sergeant, and the company commander was each in his turn a barrier to be surmounted before one's name was put on the sick book and then he was apt to go through the experiences above mentioned. Don't tell the soldier to come a-running unless you are going to get somewhere and get there quickly and easily."

Major Goldman says that although these views were not considered "representative," they did reveal an "extreme degree of negative feeling." It was agreed one of the reasons for complaints was the fact that the medical officer was "inundated with cases on sick call," and saw many men who had minor ailments. Consequently, he was not particularly sympathetic where "demonstrable organic pathology" was not present. "If he is not aware of the role that anxiety and worry play in the development or amplification of symptoms," Major Goldman writes, "he is likely to be at a disadvantage in his task of being the 'family doctor' to his many patients."

> "The method of the family doctor is needed—a family doctor who is also a medical officer—who handles his patient's anxieties at the same time that he treats the sprained ankle or sore back. He knows that a man's worries about family troubles or his disappointment about promotion may have something to do with his headache or stomach trouble. He gives medical attention to the symptom, and by his manner and approach to the patient he handles the human factors that have much to do with the severity of the symptom in that particular case. When the disturbance is not particularly serious or in any sense permanent, he knows that the patient needs reassurance to that effect. He knows that a man in basic training who is worried lest the rigorous training may impair his health has a greater need of reassurance from the medical officer than he would in civilian life. The doctor knows that a brief examination may be enough to assure himself that organic findings are minimal or negative, but he also knows that it is important that the examination involve sufficient manual manipulation and examination so that the patient will confidently feel that he has been well examined.
>
> "Along with the treatment, a rational explanation of the symptoms is called for. The symptoms may be explained in terms of unaccustomed physical stress, nervous tension, or a minor muscular strain. In other words, the patient should be put on the pathway back to duty with a feeling that somehow his trouble is understood, that it is not too bad, and that he will get better. The family doctor knows that the average person expects some medicine for his ills, knows that the 'right medicine' is actually a combination of two factors: the symptomatic relief inherent in the medication and the personality of the doctor who administers it. If the medical officer is resourceful in his use of the 'right medicine,' he has a very powerful psychological instrument. If he is unimaginative, unenthusiastic, or overly routine in this matter, the patient feels cheated, resentful, and goes away saying, 'All they ever give you is aspirin.'
>
> "Nothing is achieved by resentment on the part of Medical Department personnel because the man on sick call has minimal organic findings. Shaming him, hostile and humiliating remarks, free and easy name-calling—'gold brick,' 'faker'—this method of handling men is harmful and an admission of inability to cope with the situation. It may force the patient, in order to 'save face,' to complain more persistently, thereby tending to implant the symptoms more securely rather than to remove them. Or, the patient may be intimidated so that he stays off sick call, but feels more convinced than ever that something is wrong physically."

In other words, he cautions, "A good family doctor invariably uses sound principles of psychology in his practice."

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Radio Advertising Menaces Health

Periodically, your Observer has chided broadcasting companies for their indifference to public welfare where health is concerned. The basis for his complaint has been their acceptance of advertising which is, to say the least, misleading. Ridiculous claims made for so-called remedies would be laughable if it were not for the damage they do. It appears that the old medicine show, having moved from under canvas to the respectable and far more luxurious broadcasting stations, has found a secure and vastly profitable haven.

Of course, your Observer has not been alone in protesting the indifference of the broadcasting industry to this menace to public health. Recently, Dr. Thomas Parran, Surgeon General of the United States Public Health Service, had something to say on the subject. Speaking before the Section on Food, Drug and Cosmetic Law, New York State Bar Association, on June 25, 1946, Dr. Parran said:

> "In our efforts to protect the public in the manufacture and sale of food and drugs, we cannot help feeling a deep concern over some of the advertising techniques promoting the sale of products to the general population. In this field standards self-imposed by the industries are urgently needed. I am referring particularly to the widespread use of extravagant claims and promises held out or im-

plied in drug advertising on the radio. At almost any hour of the day, listeners may hear announcements offering relief for a wide variety of human ills. In many of these cases no factual information is supplied to limit the hopes that may be aroused by the appeals. Although the physician is referred to at times in glowing terms, there is too seldom any reference to the importance of seeking competent medical diagnosis or treatment. An announcement which recommends that a certain product be taken every morning and night by everyone over 35, or states that 3 out of 4 persons suffer from vitamin deficiencies which are correctible by taking X brand of vitamins, obviously is not in accord with the therapeutic needs of the population. These are only samples of a trend that in my opinion is reaching disturbing proportions.

"In the American pattern, any product which is to be sold widely must be advertised. Radio is an important medium. Often, however, the enthusiasm of the sponsor gets out of bounds.

"In setting improved standards for drug advertising, radio can look to an excellent example. Some years ago the newspaper industry took aggressive action in cleaning up drug advertising in their columns. A few representatives and socially conscious newspapers of the country led the way and most of the others since have followed. Today many papers go so far as to conduct surveys to be sure that advertised products conform to established standards.

"It is not too much to hope—even to expect—that the radio industry will do the same or even a better job once the need for such action has been made clear. Radio's contribution to public service has been notable. It has contributed to the advancement of health knowledge among the masses of our people.

"The establishment of safeguards in drug advertising offers another opportunity for public service. You who are so keenly interested in both the welfare of the drug industry and the rights of the common man might appropriately work out this matter with the leaders of radio and advertising."

We sincerely hope that the New York State Bar Association will take the step suggested by Dr. Parran, and that the medical profession of the state will give it wholehearted support. Obviously, the situation is not readily corrected, for there is too much money involved. But with persistence and an adequate public educational program, the air should be cleared of "medicine men."

Illustrative of the attitude of racketeers in the health field is an incident which occurred several years ago. Your Observer had received complaints about a "doctor" holding forth in the basement of a large five-and-ten cent store in the Midwestern city in which he was then living. He went down to see for himself what was going on. A shifty man of uncertain age in a white coat, holding a skull in one hand and a pencil in the other, was explaining to a group of customers how sinus infections might cause insanity. This could be avoided, he explained, if Dr. Buncombe's nose drops were used. A call on the manager of the store resulted in the prompt departure of this "medicine man."

A few days later, the "doctor" called at the Medical Society's office, protesting vigorously your Observer's interference. He said that there was no good reason for it, because the drug that he was selling was harmless. And he argued there are just so many suckers who are going to part with their money anyway, and he might as well have some of it.

Broadcasting companies should not permit themselves to be used by slick operators. That is a violation of public trust. They are obligated to exercise the greatest care in accepting advertising accounts which in any way involve the health of the people.

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California Victory?

California doctors have long sought a new deal in the American Medical Association. At first, their efforts were attended with little success; however, in recent months, their prospects have brightened considerably. As your Observer has stated on other occasions, leaders in California medicine today are an extremely able group, and it will be surprising, indeed, if they do not exert a tremendous influence on the Association's future.

Your Observer read with considerable interest an editorial in the *Bulletin of the San Francisco County Medical Society* for August 1946 by Dr. Robertson Ward. Dr. Ward, who describes himself as the "baby" member of the AMA's House of Delegates, states the objectives of the California Medical Association as follows: "They are elimination of Dr. Fishbein as spokesman for American medicine, proper and adequate representation in Washington, and energetic furtherance of voluntary health services."

"It can be seen at a glance," he continues, "that the first two of these objectives are interdependent and that the second and third are closely intertwined in that Washington activity is to combat compulsory plans while voluntary systems, if widely enough distributed, will cut the ground from beneath the proponents of compulsion."

As might have been expected, CMA took full advantage of the fact that the meeting was held in San Francisco. In estimating the results, Dr. Ward poses these questions, "What was accomplished by the meeting? Did California get taken for a ride? Was Fishbein muzzled? Did the AMA further the cause of voluntary service systems? Are we to have satisfactory representation in Washington?". To which he replies, "None of them can be answered by a categorical 'yes' or 'no.'" However, Dr. Ward believes, and he undoubtedly reflects the views of his colleagues, that much of what CMA sought will be realized as a result of the survey of the AMA's public relations made at the instance of the Board of Trustees by the Raymond Rich Associates.

Among this firm's recommendations, Dr. Ward asserts, were the three objectives of California. "In fact, the three motions passed by the House at this meeting in relation to this report were the outlining of Dr. Fishbein's duties, the employment of a top-notch economist and the selection of a nationally known public relations expert to be responsible to George Lull, the new secretary and general manager."

In light of the action taken by the Board of Trustees and the approval given by the House of Delegates, he feels certain that California can be reasonably assured that the policies it advocated for the past five years will be carried out. He says he is convinced, "We were not 'sold down the river.'"

★

A Long, Long Trail

Readers of this column will recall that in a previous issue of the MEDICAL ANNALS, mention was made of the Society's correspondence files long gathering dust in a neglected storeroom, and that among papers examined by your Observer and his secretary, few were of any historical value. Among those worthy of preservation were several addresses made by Dr. Arthur C. Christie, President of the Medical Society of the District of Columbia, in the years 1931 and 1932. Your Observer was impressed by the general excellence of this material. Dr. Christie fully appreciated the gravity of the issues confronting medicine, and he presented his views with clarity and forcefulness. Through his writings on the social and economic problems of medicine, he became a national figure. He foresaw, better than most, the complications which ensued in later years, and the controversial issues that somehow would have to be dealt with. For many years, he labored diligently to help solve them, but progress was slow, most physicians lagging far behind in their thinking in such matters.

In one of his addresses while President of the Medical Society, Dr. Christie said:

> "Many important problems confront the medical profession for settlement, if not within the next year, certainly in the near future. Everyone acquainted with the trend of the times admits that there must be changes in the old type of medical practice to conform to our rapidly changing, highly organized society of the present industrial age. It is the work of organized medicine to see that all proposed changes are wisely conceived and that they are carried out in a constructive way. Whatever changes must come in medical practice, it is the place of physicians coöperating in their medical society to resist all efforts to destroy the fundamental ideals upon which medicine is founded. It is possible, for instance, that there needs to be better organization within the medical profession to the end that more efficient medical care may be rendered at a lessened cost, but if such organization

> is to destroy the personal relationship of the physician with his patient, the supposed gain will be only loss to both patient and physician. It is the aim of our Medical Society to be open-minded to all new truths, but to be sure that such truths can be rationally related to the whole body of established and organized knowledge. It is only so that progress along sound lines can be assured."

While Dr. Christie was aware that some solution would have to be found to problems relating to the distribution and costs of medical care, he was more optimistic than subsequent events justified. If he could have foreseen how long the road, his enthusiasm would undoubtedly have been dampened. As it was, his confidence never waned. He carried on energetically down through the years, and is still actively interested.

Although all that he hoped for has not been realized, Dr. Christie has the satisfaction of knowing that the seeds he planted in other medical men's minds made them think. That marked the beginning of progress.

★

"Duty Will Page You..." Several weeks ago, the Medical Bureau Committee addressed a communication to the Society's membership announcing the availability of mobile radio service. The Committee warned that the service was still in its experimental stage, and that the Federal Communications Commission was issuing only experimental licenses, and had not yet decided that permanent licensing was feasible.

Beginning August 1, it was stated, the Chesapeake and Potomac Telephone Company was offering urban radio telephone service to a limited number of individual subscribers. Members were asked whether they favored (1) MEDICAL BUREAU establishing mobile radio service of its own, (2) entering a group contract, if possible, with another private organization, or (3) each member contracting for individual service, with a common carrier, like the telephone company.

Response to this communication was smaller than anticipated. Only 47 replied, 15 of whom favored the establishment of a mobile radio service by MEDICAL BUREAU, 2 who wished to enter a group contract, and 25 who felt physicians should individually subscribe to the telephone company's service. While several of those who replied were enthusiastically in favor of this new means of communication, others were lukewarm. One physician said he would like to get away from his practice, and would prefer not to have his privacy disturbed. Another said, "I think the whole proposition perfectly silly." Why it was silly, he did not say. Perhaps he had in mind the advice doctors are constantly giving their patients to relax. The inconsistency of physicians in this respect is commented on in "Topics of The Times," appearing in the *New York Times* for August 30.

> "What does the doctor so often tell his patients as part or the whole of the answer?" the writer inquires. "He orders the patient to relax, to take things easy. But when the overworked doctor himself seeks a few hours of relaxation in the theatre or the ball park, he can now be paged by 'radio-phone.'
>
> "It will be done discreetly. The doctor will carry with him a receiver not much larger than a pack of cigarettes and every little while he can put it to his ear to find out if his code number is being sounded."

Perhaps there is no escape for the physician, and he might as well accept such gadgets as the radio-telephone and use them.

> "The poet remarked long ago," the *Times* writer continues, "that when Duty says 'Lo, thou must,' the youth replies 'I can!' The poet could hardly have foreseen a time, like our own, when it has become virtually impossible to get away from the call of duty for a couple of hours in Central Park or the Yankee Stadium. Duty will page you and track you down by radio signals, and if by chance you have managed to evade the stern summons, Duty will leave her message for you at home on the new automatic recording telephone. Flee for your hard-earned vacation to the Canadian woods or where rolls the Oregon, and the radiophone will hunt you down in your sub-Arctic fishing lodge and the airplane will bring you back into harness in a matter of hours."

Despite all this, the commentator concludes, "One must remember that a great secret of health is to relax." Undoubtedly good advice, but—.

Don't Be Taken In

Few secrets of any importance, especially those having to do with the Government, are kept in Washington. This is not surprising when one considers the never-ending struggle for political advantage. There is no hesitancy, even in national emergencies, to circulate so-called inside information if it is thought it will further a cause or someone's ambitions. So, when doctors living outside the Nation's Capital are led to believe they are being given facts that are not in possession of others, chances are that they are being "taken in."

An example is the "discovery" that sinister forces are at work trying to socialize medicine. Mention is often made of such names as A. J. Altmeyer, Chairman, Social Security Board, Isadore Falk, Director, Bureau of Research and Statistics, Federal Security Agency, and others. Now, there is nothing startling about the fact that these men have long been ardent advocates of compulsory health insurance, nor is it news that they have helped draft national health legislation objectionable to the medical profession. In fact, they themselves have not been loath to admit nearly all that has been said about them in this regard.

Everyone knows, too, where Senators Murray and Pepper stand on health legislation. They have made it clear time and again. Few are so uninformed as not to be familiar with the views of Senator Taft. This is equally true of other legislators in the Nation's Capital. So, when doctors throughout the country believe they are getting inside information about members of Congress, they are being naïve.

Now it is true, of course, that there are some advantages in being an on-the-spot observer. One senses attitudes which are often as important, even more so, than the words spoken. One becomes sensitive, too, to trends before they are apparent elsewhere. These factors are difficult to convey to others, but are, nevertheless, very real.

Speaking of attitudes, one is impressed by the cynicism in high places. This is not too surprising in view of the turbulence of the times, although it is not conducive to sound leadership. Most disturbing of all is the lack of idealism. However, this isn't confined alone to leaders in Government. Your Observer's impression is that it is pretty general throughout the country. This is something to be deeply concerned about, and a situation which can only be corrected when our people come to the realization that materialism may lead to their undoing.

Out of our attitudes toward life will come the trends which will fashion America of tomorrow. Today, it appears that we are veering leftward toward collectivism. But tomorrow, it may be another story. The uncertainty which surrounds us naturally does not make us happy.

In the face of all this, the play for advantage in Washington isn't too important. Our problems go much deeper than that. They lie within the people themselves.

★

A Citizen of Loudoun County

The quiet exit made by Dr. William J. Mallory from the Washington medical scene is typical of the man. Modest, good-natured, cultured, understanding, and above all charming, his personality possesses a soothing warmth. Always ready with an apt story or saying, he is never guilty of being dull. People who engage him in conversation always come away feeling better.

One may easily be led to believe that this smiling, pleasant man is never troubled. Those who know him, know better. He is sensitive to the world's troubles, much more so than the average man. He is concerned about the future of medicine, a field in which few have had a more distinguished career. But he never lost the conviction that all will be well if everyone does his part. If not, he refuses to worry about it because it does no good.

There was, perhaps, no more popular and effective teacher at George Washington University

School of Medicine than Dr. Mallory. When the time came for his retirement and he took on the weighty title Emeritus Professor of Medicine, it seemed hardly possible, for he was and still is a youthful-looking person for his years. It would have been unnatural for Dr. Mallory not to have experienced feelings of regret at having to give up a phase of his work which he loved most. But being resourceful, he found other things to interest him. He had for some time cast longing glances at his farm in Loudoun County, Virginia. There he decided he would find contentment, doing the things he always wanted to do.

On a beautiful day in August, your Observer and his wife dropped in on the Mallorys. Never had they seen Dr. and Mrs. Mallory looking better than they did on this occasion. Dr. Mallory was keenly interested in his farm, and all that goes on there. He was very proud of the large cabinet of tools with which he works. Your Observer noted that each was in its place and in excellent condition. On the table were plans to improve the home to which Dr. and Mrs. Mallory have long been attached.

Of course, Dr. Mallory will return many times to visit his friends in Washington. Nevertheless, his unique and lovable personality will no longer remain an inseparable part of the community. That is too bad, and a real loss to the Washington physicians. But, at least, we know where to find him.

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Health Program for Federal Employees

The health program for Government employees recently authorized by the enactment of the so-called Randolph Health bill is expected to become a reality before too many months. Dr. John W. Cronin of the United States Public Health Service has been appointed to administer the program, and is at present drafting plans for the undertaking.

The Randolph bill authorizes the establishment of clinics in individual Government departments and agencies for emergency treatment. These clinics will also conduct preëmployment and periodic health examinations of Federal employees, and a program in preventive medicine. Dr. Cronin is quoted as saying that "the new program will be the end of two-aspirins-for-every-headache type of treatment."

Clinics will be staffed by full-time physicians, who will diagnose the employees' ailments and recommend treatment. Dr. Cronin made it clear, however, that the program will in no way compete with private physicians. Following diagnosis of the employee's condition, he will be sent to his personal physician. If the employee doesn't have a private physican, the health officer "will submit the names of three doctors approved by the local medical society and recommend that the employee visit one of them."

As mentioned, one of the features of the program is an annual physical examination, to be given Federal employees to establish their fitness for the jobs they hold. If found to be ill, the employee will be excused from work, and will not be permitted to return until the health officer is satisfied that he is fully recovered.

Funds for the operation of this program still must be authorized by Congress. Such authorization must be voted separately for each agency, whose health program must be approved by the United States Public Health Service.

The Medical Society of the District of Columbia and the American Medical Association both gave their support to the Randolph bill at the time hearings were held by Congressional committees. With close coöperation of the United States Public Health Service and the medical profession, the new program should prove most satisfactory from the standpoint of all concerned.

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Has Sex Been Exhausted

At the risk of being called a prude or an old fogy, your Observer is going to chance a few remarks about sex. If outward appearances are to be relied upon, the female of the species holds endless fascination for the masses. Everywhere one sees emphasis on the human form divine. Little is left to the imagination, nudity being flaunted wherever one goes.

One might argue that there is nothing reprehensible about the human form, although that may be open to debate after viewing the spectacle one sees on the bathing beaches. Very few human beings are less than vulgar in nature's clothing. For the rest, near-nudity can have only one purpose, stimulating the male of the species. Hand in hand with near-nudity goes a brand of humor which is nothing less than nasty. One hears it in so-called nice company, in the once refined legitimate theater which, in recent years, finds humor from the burlesque houses acceptable, in places of business, and many other places where such conversation was taboo. There is no longer pretense at modesty. Even a successful novel, it seems, must have so much dirt in it, if it is to be successful.

Your Observer sympathizes with the views of Dr. Frank A. Weiser, who expresses himself editorially on this subject in the August 5 issue of the *Detroit Medical News*.

> "We are one of that generation that has grown to maturity in the literary period marked off by the novel 'Three Weeks' on one side and 'Forever Amber' on the other," Dr. Weiser writes. "We lived thru the era when pictures in the Police Gazette, which graced the walls of barber shops, pool rooms, saloons and the work shops of the painted ladies, were considered decidedly pornographic. Any female who used rouge, wore scanty clothes, drank liquor, and God forbid, smoked cigarettes, was branded at once as a sister of easy virtue. We remember in Zoology I, when the professor described the sex antics of the paramecium, the uneasiness of the lady students in the class and our own embarrassment at the overt mention of things sexual in the presence of ladies. And a little later when we heard the late Dr. Warthin's celebrated lecture for men only, we were amazed to find how much of the deep secrets of life, as we learned them in the pool room, had diffused to the portals of culture.
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> "And during the roaring twenties when with equal suffrage women (up to this time referred to as ladies) assumed the freedom to frequent blind pigs, as men did, and the right to use rouge, wear scanty clothes, drink liquor and smoke cigarettes as their sisters in sin did, the whole sex deal broke wide open.
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> "Came the sex psychologists and their lectures to high school seniors, then to juniors and so on down until parents learned from their young the fine points of this bee-flower business. Sex invaded the movies and moved from the burlesque and carnival side show to our best muscial plays—came the books on sex—sex in song— in advertising—in radio—the analyses of the sex life of prince and pauper, and the series of barely clad Miss Americas, Miss Cherry Pies, Miss Illegitimate Mothers of 1920 to 1946 ad absurdum. We lived into the hear all, speak all, see all age of sex curiosity."

Where will all this sex business end? It will, perhaps, continue to a point where the situation will become so degrading that the people themselves will revolt. Efforts to correct the situation by regulatory means would only bring forth loud wails from those who are concerned lest their freedom be infringed upon. This is all very sad, but there is little to do about it. People do not change their habits of thought overnight. Events shape them, most often very slowly.

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Showman Rose on Doctors

Friends often turn up in unexpected quarters. As an example, doctors have had little to cheer about where newspaper commentators are concerned. By and large, they have not been too favorable to the medical profession. So it was a pleasant surprise, indeed, when showman Billy Rose, in his earthy, Broadwayese column, "Pitching Horseshoes," appearing currently in the *Washington Times-Herald*, came to bat for the doctors.

> "For my dough, the most important people in the world are doctors," says Commentator Rose. "If you have a bum ticker, if a sick tooth is beating drums inside your head, if your kid breaks out in spots, whom do you holler for? Truman? Henry Kaiser? Admiral Nimitz? In a pig's ear! You send for the man with the little black satchel."

Billy dispels the notion that his high regard for doctors is something that suddenly occurred to him.

> "My respect for doctors," he says, "is not something I came by an hour ago because I needed a midweek piece. I've been tipping my hat to these gentlemen ever since I had a hat. There wasn't much on the obituary page when an old friend of mine, Dr. Emanuel Libman, died a few months ago.
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> "He was a slender little party with pink cheeks and a library of classical records he never had time to listen to. During his years as head of the great Mt. Sinai Hospital, he charted a good part of what the top specialists know about your heart. A lot of people are going to see thousands of extra sunrises because of Manny Libman."

Billy concludes with these observations:

> "Of course, the great standouts of medical science don't need me to beat their drum. The Warner Brothers took care of that some years ago in their 'doctor' cycle. You couldn't go into a theater without seeing Paul Muni inoculating rabbits. But the doctor in your neighborhood, with the stethoscope and 1937 Chevvy, could use a little applause. In a society that rates a guy by how big a check he can write, he knocks his brains out for practically no dough. Remember that when you run into real trouble—something bites you in the belly, a sledgehammer starts knocking at the base of your skull, your heart is pumping like an old hot water bag—it's old Doc Sawbones who comes around and stops the hurt.
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> "To me, that's as important as anybody can get."

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HSA Has Its Say

There were a number of people, among them your Observer, who felt that Health Security Administration was subjected to unnecessarily harsh criticism at the hands of the surveyors for the Washington Metropolitan Health Council. They concurred in the view that this portion of the surveyors' findings was not as objective as it might have been, and they were pleased that officials of the organization so successfully refuted some of the criticism leveled at the Administration. The most serious charge against the surveyors was that "no adequate survey was made and that it [the agency] stands condemned before the public by the premature publication of the surveyors' report, which is full of half-truths and outright errors."

In refuting some of the findings, Dr. Henry C. Macatee, President of HSA, said, "No agency should be discarded as a misfit which has demonstrated over a period of years that pooled dimes and quarters of poor people can help maintain services the same as pooled dollars from those who can afford to give to the united campaign for funds." Dr. Macatee strongly defended the Administration's medical social work, central admitting bureau for hospitals, financial system for arranging collection of funds from poor patients who could pay hospital bills in part, and its efforts to coördinate hospitals into a more unified system. He hoped that the Council "will see for themselves the accomplishments which the surveyors did not take time to observe, and weave it [the Administration] into the community-wide picture which the entire health and hospital survey so well and frankly exposed."

HSA pledged its coöperation to the newly formed Hospital Council, the Federation of Community Chests, and the Washington Metropolitan Health Council.

T. W.

MEETINGS

Wednesday, November 13

SYMPOSIUM ON EARLY AMBULATION AND RAPID REHABILITATION OF HOSPITALIZED PATIENTS

HOWARD A. RUSK, M.D., F.A.C.P., Medical Editor, *New York Times*, will be the guest speaker. Participating will be the following physicians who will discuss the subject from the viewpoint of the fields of medicine indicated:

Medicine—HUGH H. HUSSEY, M.D., F.A.C.P., Associate Clinical Professor of Medicine, Georgetown University School of Medicine

Surgery—J. ROSS VEAL, M.D., F.A.C.S., Associate Professor of Clinical Surgery, Georgetown University School of Medicine

Obstetrics—WILLIAM D. TERRELL, M.D., Clinical Instructor in Obstetrics and Gynecology, George Washington University School of Medicine

Wednesday, November 20

This will be a joint meeting with the *Baltimore City Medical Society*. JOHN HUGH MULHOLLAND, M.D., F.A.C.S., Professor of Clinical Surgery, New York University, New York City, will be the speaker. He will discuss "Maintenance of Fluid Balances in Surgical Patients."

ARMY INSTITUTE OF PATHOLOGY AND AMERICAN REGISTRY OF PATHOLOGY

Army Institute of Pathology

What is now known as the Army Institute of Pathology was established in 1863 as the Army Medical Museum. During World War II the activities of the Institute were greatly expanded, especially in the field of diagnostic pathology and research. There are now on file over 170,000 accessions. The results of research at the Institute during the past few years will be published in a volume of about fourteen hundred pages as a part of the official history of World War II. The present Director is Colonel J. Earle Ash, who will be succeeded on October 1 by Colonel Raymond O. Dart.

On request of Major General Norman T. Kirk, The Surgeon General of the Army, the Committee on Pathology of the National Research Council, Division of Medical Sciences, in late 1945 prepared a report on the future development of the Institute. The report has been approved by the Surgeon General and by the War Department.

The essential recommendations in this report are: (1) that a new building of adequate size be constructed; (2) that the Institute be organized in four divisions—Department of Pathology, Army Medical Illustration Service, Army Medical Museum and American Registry of Pathology—each headed by a competent specialist; (3) that the staff of the Institute be drawn from both the commissioned ranks of the Army and from the civilian professions; (4) that a comprehensive educational and training program be undertaken; (5) that the vast store of material at the Institute be used for research, and (6) that the services in pathology in the Veterans' Hospitals be centralized at the Institute.

The American Registry of Pathology founded in 1922 thus is, and will continue to be, an integral part of the Army Institute of Pathology. There were, on January 1, 1946, over 43,000 cases registered. To effectuate the new plans as they relate to the Registry, the National Research Council, Division of Medical Sciences, appointed a Committee on the American Registry of Pathology. The members of the Committee are Dr. Howard T. Karsner, Cleveland, Chairman; Colonel Ash, Washington; Brig. General George R. Callender, Washington; Colonel Balduin H. E. W. Lucké, Philadelphia; Dr. Robert A. Moore, St. Louis; Dr. Benjamin Rones, Washington; Dr. A. R. Shands, Jr., Wilmington, Del., and Henry A. Swanson, Washington.

At the present time there are fourteen registries as a part of the American Registry of Pathology. These include Registry of Ophthalmic Pathology, established in 1922, sponsored by the American Academy of Ophthalmology and Otolaryngology; Lymphatic Tumor Registry, established in 1925, sponsored by the American Association of Pathologists and Bacteriologists; Bladder Tumor Registry, established in 1927, Kidney Tumor Registry, established in 1940, and Prostatic Tumor Registry, established in 1943, sponsored by the American Urological Association; Registry of Dental and Oral Pathology, established in 1933, sponsored by the American Dental Association; Registry of Otolaryngological Pathology, established in 1935, sponsored by the American Academy of Ophthalmology and Otolaryngology; General Tumor Registry, established in 1937, sponsored by the American Society of Clinical Pathologists; Registry of Dermal Pathology, established in 1938, sponsored by the American Academy of Dermatology and Syphilology; Chest Tumor Registry, established in 1942, sponsored by the American Society of Thoracic Surgeons; Registry of Neuropathology, established in 1943, sponsored by the American Association of Neuropathologists; Registry of Orthopaedic Pathology, established in 1943, sponsored by the American Academy of Orthopaedic Surgeons; Registry of Veterinary Pathology, established in 1944, sponsored by the American Veterinary Medical Association; and Registry of Gerontology, established in 1945, sponsored by the Gerontological Society, Inc.

Plans for additional registries are under consideration. A professional scientific society wishing to sponsor a registry should communicate with the Director, Army Institute of Pathology, 7th Street and Independence Avenue, S.W., Washington 25, D.C. The society appoints a committee to work with the Director in supervision of the activities of the registry, and makes an annual contribution to the budget which is administered by the National Academy of Sciences.

All specimens in the registry are available for review and research by competent investigators. Sets of slides and accompanying syllabuses on special fields are available for loan to the civilian professions and officers in the Federal services. Physicians, dentists and veterinarians are urged to send unusual specimens together with an abstract of the history to the registry. The contributor receives a report on each specimen and is asked to keep the registry informed of the follow-up on the patient.

With the reorganization of the Army Institute of Pathology to be completed during 1946 and 1947, a full-time scientific director of the American Registry of Pathology will be appointed and sufficient clerks and technicians will be available to assure adequate use of the registries for diagnosis, research, training of young men, and education of the professions.

American Registry of Pathology

Many diseases are so rare that any one individual or even the staff of any one hospital or clinic has a limited opportunity to study certain conditions and lesions. Conclusions in science must be based on not one, but many observations. Therefore, it is desirable to organize and support central agencies for the collection and filing of histories, specimens and follow-up studies.

For over twenty-four years the American Registry of Pathology has been maintained at the Army Institute of Pathology in Washington. It was founded in 1922 by the then Curator of the Army Medical Museum, Brig. General George R. Callender, at the request of the American Academy of Ophthalmology and Otolaryngology. Succeeding Curators, Major Paul E. McNabb, Colonel Virgil H. Cornell, Colonel Raymond O. Dart, and Colonel J. Earle Ash, have given time and thought to the problems of the Registry. On January 1, 1946, material from over 43,000 cases was on file.

There are now fourteen separate registries, each sponsored by a professional scientific society. Important additions to knowledge have been made by investigations at the Registry notably on tumors and diseases of the eye, tumors of the lymphatic system, and tumors of the bladder.

With the reorganization of the Army Institute of Pathology and with plans for the erection of a new building, sponsored by Major General Norman T. Kirk, The Surgeon General, the American Registry of Pathology takes on increased importance. There will be greater opportunities for the training of specialists, for research, and for educational activities.

The American Registry of Pathology deserves support from the civilian profession in terms of contributions of materials by individuals and sponsorship of registries by societies.

FEDERAL HOSPITAL COUNCIL TO ADMINISTER HOSPITAL ACT

Formation of a Federal Hospital Council and an Advisory Committee to assist Surgeon General Thomas Parran of the U. S. Public Health Service in the administration of the Hospital Survey and Construction Act was announced September 12 by Federal Security Administrator Watson B. Miller. The Council will be composed of the Surgeon General, who will serve as Chairman ex officio, and eight members appointed by Mr. Miller. Members representing the hospital and health fields are Dr. Albert W. Dent, President, Dillard University, New Orleans, La; Very Reverend Monsignor John J. Bingham, Director, Division of Health, Catholic Charities, New York City; Mr. Graham Davis, Director of Hospitals, Kellogg Foundation, Battle Creek, Michigan; Dr. Robin C. Buerki, Dean, Graduate School of Medicine, University of Pennsylvania, Philadelphia, Pa.

Council members representing the consumers of medical services include Dr. Michael M. Davis, Committee for the Nation's Health, New York City; Honorable J. Melville Broughton, Attorney-at-law, Raleigh, N. C.; Mrs. Evelyn Hicks, Radio Station WTMB, Birmingham, Ala.; Mr. Clinton S. Golden, United Steel Workers of America, Pittsburgh, Pa.

Mr. Miller pointed out that the Federal Hospital Council is unique in that the Act vests it with certain administrative functions. These include the approval of general regulations under which the program will operate.

Members of the Advisory Committee will serve as consultants to the Surgeon General and the Federal Hospital Council in the administration of the Act. Invitations were issued to 24 leaders in the fields of medicine, social service, public welfare,

(Continued on page 523)

President's Page

THE CANCER PICTURE

Cancer is one of the most important subjects in the public mind today, for every life is menaced by this dread disease. Is there hope for a cure? If so, is it near at hand? The secret is locked up in the complex, incomprehensible problem of organic chemistry. This is in marked contrast to inorganic chemical and physical problems.

Research projects delving into the problems of individual cell chemical analysis are pointing the way to the ultimate answer. The more one learns of the present store of data the more impressed one becomes with his inability to begin to understand a small fraction of this fundamental chemistry. Millions of dollars are being expended in search of the answer.

It is well to remember that in rare instances patients spontaneously lose all traces of malignant involvement in ways which we do not understand. In addition to this we know that Coley has, also in rare instances, accomplished cures of malignant conditions. We know that temporarily we have been successful in controlling malignancy by values in steroid imbalances. We have recently seen a successful fight against dog distemper, a virus problem, through the method of ferret serum.

These observations suggest considerable interest in the field of producing immunity against malignancy by either active or passive methods. Those authors consulted by Congress in their recent dilemma when the appropriation for cancer research was under consideration very wisely stated that this project was not comparable to the Manhattan Project. It would seem worthwhile if the interest of Congress might be directed toward providing resources for work in the field of immunity.

William P Herbst Jr

Veterans' Affairs

WALTER REED'S NEW DEPARTMENT OF PHYSICAL MEDICINE

Brigadier General George C. Beach, Jr., Commanding General of the Army Medical Center and Walter Reed General Hospital, has announced the establishment of a new division at the Hospital, to be known as the Department of Physical Medicine. The new department, the first to be established in any United States Army hospital, will be under the direction of Captain George W. Soffe.

Under the new plan at Walter Reed, the agencies which carry recovery beyond the stage of surgical and medical treatment are combined. Physical Therapy, Physical and Educational Reconditioning, and Occupational Therapy will function as a unit under Captain Soffe's direction.

Each wounded veteran is referred to this clinic by his own ward doctor, with a statement of his diagnosis and the results desired. After careful study and analysis of the individual case, a schedule is worked out so that under a combination of treatment and self-help, a man may learn to live a normal life in spite of handicaps.

The widespread Army Reconditioning Program has been developed through intense research during the last three years. It serves to restore lost faculties to men, and where that has not been possible, to substitute new skills and abilities. If a man has lost his right arm, he learns to write with his left hand, or to operate a typewriter with a single hand. If he has lost one or both legs, he learns to drive a car by using hand devices. Exercises are worked out under the direction of highly trained experts to benefit each type of case, so that he may be physically fit to profit from the variety of trades and skills which are available to him.

He acquires manual and/or pedal dexterity, strengthens atrophied muscles, and builds up his general condition through seemingly simple operations, such as weaving or running a press, under the direction of trained technicians who know exactly how each motion will affect each muscle.

Physical Therapy supplies heat, light, electrotherapy, hydrotherapy, massage and therapeutic exercise to carry this work forward. Optimum conditions are established for nerve regeneration, and muscles kept so strengthened that they are ready and waiting to function upon nerve recovery.

It is not sufficient to provide prosthetic limbs for amputees; they must be taught to use them. This delicate and laborious process is handled for men who have lost arms or hands by Occupational Therapy, where the simple motions of daily living are taught first, more complicated skills later. A room has been set up which incorporates the articles found in the every-day American household: a stove, electric refrigerator, bathroom equipment—parlor, bedroom and bath, in fact. The patients are given all the time they require, with supervision and suggestions, until they once more can cope with the problems of dressing eating, etc. Physical Therapy teaches men to walk again, teaches the coördination and balance which can make an artificial limb an almost living adjunct.

LEGION OF MERIT AWARDS FOR WASHINGTON PHYSICIANS

Drs. James N. Greear, Jr., and John Minor, both Active members of the District Medical Society, have recently been awarded the Legion of Merit medal by Surgeon General of the Army Norman T. Kirk.

Dr. Greear was decorated together with three Army Medical Corps officers, Brigadier General Raymond W. Bliss, Deputy Surgeon General, Colonel Roger G. Prentiss, Jr., Deputy Chairman of Army Medical Research and Development Board, Office of the Surgeon General, and Colonel Ralph V. Plew, who was senior medical officer of the Chinese Medical Liaison Group from September 1945 to April 1946. The medals were pinned on the officers by General Kirk at a special ceremony in his office. Citations were read by Colonel Howard W. Doan, Executive Officer, SGO.

General Bliss, according to the citation, "distinguished himself as Surgeon, Eastern Defense Command and First Army from June 1942 to June 1943. He organized and supervised the Army Medical installations, service and personnel of the widely dispersed elements, both continental and at overseas bases, of this command."

As a Lieutenant Colonel, Dr. Greear "rendered distinguished service as Chief of the Eye, Ear, Nose and Throat Service, Valley Forge General Hospital, Phoenixville, Penna., from October 1943 to February 1945. Through his outstanding background, tact and professional ability, Colonel Greear contributed greatly to facilitating the high standard of care rendered blind patients . . . ."

Calendar of Meetings

September 6	Committee on Arrangements, Annual Scientific Assembly Attendance Committee, A. S. A.
September 9	Public Relations Committee
September 11	Cancer Control Committee
September 13	Radio Education Committee
September 16	Committee on Medical Care
September 17	Classification Committee
September 18	Special Business Meeting of Society Sports Committee
September 19	Social Affairs Committee, A. S. A.
September 20	Committee on War Souvenirs Exhibit, A. S. A.
September 23	Executive Board
September 25	Incorporators of Medical Service

Dr. Minor, former Colonel in the Medical Corps, was decorated for his work when "as medical consultant to the Surgeon of the Third Service Command from December 1944 to December 1945 he raised the professional standards of the various hospitals of his command to a high degree of efficiency. By his leadership and exceptional professional ability he rendered outstanding services, thereby reflecting credit on himself and the military service."

Dr. Minor also served as Chief of the Medical Service, Woodrow Wilson General Hospital, Staunton, Virginia. He was named medical consultant to the Secretary of War through the Surgeon General.

SELECTIVE SERVICE HONORS LEAHY

William E. Leahy, District Director of Selective Service, was awarded the President's Medal for Merit, September 10, by Major General Lewis B. Hershey at a ceremony in National Selective Service Headquarters.

The President's citation accompanying the award stated:

> "Mr. Leahy . . . assumed his duties at the supremely critical time when Congress and the Nation were in the heat of a critical discussion over expansion of draft service. Refusing to accept any compensation for the exacting tasks he knew would be ahead, he consecrated himself and his rare qualities to bringing to his new office the same success that had attended his every previous public and private undertaking.
>
> "His efficient office judiciously and effectively solved the normal problems of a State headquarters and with equal satisfaction administered the excessive burdens incident to a doubled population of Government employees whom the requirement of teeming wartime activity would find difficult to spare for military service. With patience and understanding, firmness and tact, he allocated manpower without serious complaint either inside or outside his jurisdiction.
>
> "He administered unique problems of racial minorities and the registration of Americans in foreign residence with an efficiency which served his country well and brought credit to selective service. That the District of Columbia furnished 97,515 men to the military arms of the Nation is in no small measure due to his exemplary administration. Working in the glare of national attention in the Nation's Capital, and under the sharp eye of an alert press, by his every official act, he raised himself in the public esteem and made easier the task of the Selective Service System."

Mr. Leahy, a prominent lawyer, is well known to Washington physicians. He assumed his duties as Director of Selective Service in August, 1941.

Washington Physicians of Yesterday

GRAFTON TYLER, M.D.

Dr. Grafton Tyler was born November 21, 1811, in Prince Georges County, Maryland, and graduated as M.D. in 1833 at the University of Maryland. After a period of active practice in Maryland, he removed to Georgetown in 1845 and engaged in medical practice there for the remainder of his life. He joined the District of Columbia Medical Society in 1846, and was active in its affairs in committee and official service, becoming its President in 1872. He was Vice President of the American Medical Association in 1855–56. As Professor of Medicine in the Columbian Medical School, 1846–59, he was a popular and effective teacher. He rendered civic service to the municipality of Georgetown as President of its Board of Health and of its Board of Council, and was actively connected with the organization of Providence Hospital and Children's Hospital. A man of superior ability and qualifications, he had a large practice and was of high standing in his profession and the community. Although his published literary contributions were few, his public addresses were favorably received, he being a fluent and forceful speaker.

(*Continued on page 524*)

News and Personals

As a supplement to the regular curriculum for classes of medical officers receiving basic instruction at the **U. S. Naval Medical School,** National Naval Medical Center, Bethesda, Md., the administration plans to procure the services of at least one especially qualified guest speaker a month to deliver a lecture upon a medical or surgical topic of current interest and of timely importance. These lectures are scheduled for one Thursday a month from October 1946 through June 1947 at 8:15 p.m. While the classes are particularly for the benefit of medical officers under instruction, an invitation to attend is extended to doctors attached to the George Washington and Georgetown University Schools of Medicine and to members of the Medical Society of the District of Columbia.

Following are the guest speakers and subjects of papers for the first series of lectures:

October 17—Dr. E. B. Astwood, Boston, Mass.: "The Role of Propyl Thiouracil and Related Drugs in the Management of Thyrotoxicosis"

November 14—Dr. Julius Lempert, New York City: "The Fenestration Operation for Progressive Deafness"

December 12—Dr. George Crile, Jr., Cleveland, Ohio: "Fluid and Electrotype Balance in the Postoperative—a Rational Rationale"

January 9—Captain R. H. Draeger, M.C., U.S.N., Naval Medical Research Institute: "Bikini's 'Tip' to Medicine"

January 30—Dr. Edward A. Strecker, Philadelphia, Pa.: "Lessons of War Psychiatry"

The second series of lectures will be announced in the January 1947 issue of the Annals.

Rear Admiral T. C. Anderson, M.C., U.S.N., Medical Officer in Command of the Medical Center, who issued the invitation, stated that the intermingling and association of civilian and service doctors, particularly when they reside in the same local community, is regarded as a wholesome thing and a practice which should be mutually beneficial. By way of giving further expression to this idea the officer staff of the National Naval Medical Center will be hosts at refreshments following each lecture.

The American Association for the Study of Goiter again offers the **Van Meter Prize Award** of $300 and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The Award will be made at the annual meeting of the Association, which will be held in Atlanta, Georgia, April 3–5, 1947, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed 3,000 words in length; must be presented in English, and a typewritten, double-spaced copy sent to the Corresponding Secretary, Dr. T. C. Davison, 207 Doctors Building, Atlanta 3, Georgia, not later than January 1, 1947.

Dr. Oscar B. Hunter suggests that those who plan to attend the next annual meeting of the **American Therapeutic Society** should make hotel reservations immediately. Members will convene in Atlantic City, New Jersey, June 6 and 7, 1947, just prior to the annual session of the American Medical Association. Accommodations are available at the Chalfonte Hotel from Thursday, June 5 through Sunday, June 8, with the provision that the reservation can be extended through the meeting of the AMA. However, such reservations must be made with the Hotel at once.

The Program Committee is ready to receive titles of papers for the program. These titles should be sent to Secretary Hunter's office at 1835 Eye Street, N.W., without delay.

The Southern Medical Association will hold its 40th Annual Meeting in Miami, Florida, November 4–7, 1946. For further information see page VIII of this issue.

The 74th Annual Meeting of the American Public Health Association will be held in Cleveland, Ohio, November 12–14. This will be the first full-scale convention of this professional society of public health workers since 1942. A meeting of allied organizations will be held November 11.

Eleven hospitals in the Washington Metropolitan Area are included among 1,652 in the United States and Dependencies which have been designated by the Civilian Production Administration as "depots" for **civilian distribution of streptomycin.** They are Alexandria, Doctors, Emergency, Freedmen's, Gallinger, Garfield, Georgetown, George Washington, Providence, Sibley, and the Washington Sanitarium. The CPA said any undesignated hospital or any physician may apply to the nearest "depot" hospital for the drug when its use is indicated by medical diagnosis. If the application is denied, an appeal may be made to CPA's chemical division here. The drug will be placed in ordinary commercial distribution as soon as the supply is considered ample.

The War and Navy Departments, the U. S. Public Health Service, and the Veterans Administration have coöperated in the establishment of an **Interdepartmental Committee for the Coördination of Medical Training Film Production.** It is the purpose of this committee to develop production facilities and programs in an orderly and balanced manner and to eliminate in so far as is possible unnecessary duplication of effort. All visual aids planned and produced are being classified under a limited number of headings, each representing a general field of knowledge pertinent to medicine. It is the desire of all concerned to make available in the future motion pictures and other visual aids for loan to medical schools, medical groups, individual physicians, and those engaged in activities considered a part of medical service. Among the agency representatives for the Bureau of Medicine and Surgery is Captain L. R. Newhouser, M.C., U.S.N.

The American Book Center for War Devastated Libraries, Inc., with offices in the Library of Congress, has been created for the purpose of replenishing devastated libraries of the world. It will carry forward the work of the Committee on Aid to Libraries in War Areas which was established in 1942.

Runs of volumes, single volumes, or even single issues of scholarly medical or dental periodicals, with special emphasis on the last 15 years, are requested. Journals most desired are the *Journal of the American Medical Association*, *Surgery, Gynecology and Obstetrics*, *American Journal of Surgery*, *New England Journal of Medicine*, *New York State Medical Journal*, *Southern Medical Journal*, *Journal of the Association of American Medical Colleges*, *American Journal of Public Health*, and the weekly *U. S. Public Health Reports*.

Members of the Society having books or journals to contribute may leave them in the Medical Society's building, where they will be collected from time to time by the American Book Center.

Dr. Charles M. Griffith, Manager of Veterans Administration, in a recent letter to the Medical Society, stated that a number of positions will be open at this Hospital (Mt. Alto) for physicians who would like to work a few hours each night. He believes the pay will be quite attractive, and the hours can be adjusted to suit the individual's free time. Any physicians interested in such a position should contact the Chief Medical Officer at the Hospital, telephone Woodley 5800.

"**Enlist for Better Hearing**" has been chosen as the slogan for this year's **National Hearing Week,** November 10 to 16.

The faculty of **George Washington University School of Medicine** has been augmented by the appointment of 17 additional physicians. They are as follows:

Thomas M. Brown, Adjunct Clinical Professor of Medicine; J. Keith Cromer, Clinical Instructor in Obstetrics and Gynecology; James Q. Gant, Clinical Instructor in Dermatology and Syphilology; William Travis Gibb, Assistant Clinical Professor of Medicine; Brig. Gen. Wallace H. Graham, Professorial Lecturer in Surgery; Webb E. Haymaker, Professorial Lecturer in Anatomy; Vincent M. Iovine, Adjunct Clinical Professor of Surgery; Lewis W. McIlhany, Clinical Instructor in Public Health Practice; Lloyd H. Mousel, Clinical Professor of Anesthesiology; Jed W. Pearson, Jr., Clinical Instructor in Obstetrics and Gynecology; Carey M. Peters, Clinical Instructor in Medicine; Leonard T. Peterson, Clinical Instructor in Surgery; George P. Robb, Associate

Clinical Professor of Medicine; Jerome Victor Rose, Instructor in Physiology; Monroe J. Romansky, Associate Clinical Professor of Medicine; Carl H. Wells, Instructor in Pathology; and Clark H. Yeager, Professorial Lecturer on Tropical Medicine.

The New York State Society donated $2,000 to equip a "New York Room" in the new **George Washington University Hospital.** The gift was made at the Society's ball in the Shoreham Hotel, September 14, and was accepted by Dr. Walter A. Bloedorn, Dean of the Medical School, and Mr. Leo G. Schmelzer, Superintendent of the Hospital.

Children's Hospital was granted a cash bequest of $10,000 by the late Supreme Court Justice James Clark McReynolds, who died August 24. Children's Hospital was also designated, along with two other institutions, to share equally in that part of the estate which remains after the will's provisions have been provided for. This sum may exceed more than $59,000, a recent accounting disclosed.

Among the 111 physicians, surgeons and psychiatrists appointed, September 12 as **civilian consultants to the Secretary of War** were 15 from Washington. They bring the number of civilian consultants in the Medical Department to more than 200. Surgeon General Norman T. Kirk, under whose direction the program was initiated during the war, said the appointments aim at maintaining the highest standards of medical practice. Appointees from the local area and their special fields are:

Internal Medicine—Drs. Wallace M. Yater and Monroe J. Romansky
Neuropsychiatry—Drs. Walter Freeman and David McK. Rioch and Mrs. Elizabeth H. Ross
Orthopedics—Drs. Carl Berg, Milton C. Cobey and William J. Tobin
Neurosurgery—Dr. James W. Watts
Urology—Dr. Lloyd G. Lewis
Otolaryngology—Dr. William H. Jenkins
Radiology—Drs. Arthur C. Christie, Edgar M. McPeak, and Aubrey O. Hampton
Ophthalmology—Dr. L. Conner Moss

More consultants will be added in the future as the program is expanded.

The Reverend Paul A. McNally, S.J., has succeeded the **Reverend David V. McCauley, S.J.,** as Regent and Dean of **Georgetown University School of Medicine** and Regent of its Dental School. He will also be Administrator of the Hospital.

The Rev. McCauley, who has held the regencies since 1934 and the deanships since 1935, will receive a new assignment in New York. He taught biology and experimental psychology at Canisius College in Buffalo, New York, and at Fordham University and Holy Cross prior to coming to Georgetown in 1933. He is a member of the American Medical Association, the American Association for the Advancement of Science, the Association of American Medical Colleges, the American Association of Jesuit Scientists, and is an Associate member of the Medical Society of the District of Columbia.

The Rev. McNally came to Georgetown in 1926 as Assistant Director of the Georgetown Astronomical Observatory and became Director in 1928. Prior to that he was engaged in advanced astronomical study at the University of California. He also had held teaching positions at Boston College, Fordham University and Jesuit Pontifical University, Woodstock, Md. He is a member of the American Association for the Advancement of Science, the American Astronomical Society, the Astronomical Society of the Pacific, the International Astronomical Union, the American Mathematical Society, and is a Fellow of the Royal Astronomical Society. He will continue as Director of the Observatory and as Vice President of the University, which latter position he has held since 1942.

At the **Annual Meeting of the American College of Chest Physicians,** held in San Francisco, June 27–30, 1946, Major General S. U. Marietta was chosen President-elect. General Marietta is now serving as Governor of the College for the U. S. Army Medical Corps. Comdr. Sydney A. Britton was elected Governor of the College for the U. S. Navy Medical Department. Dr. Herman E. Hilleboe and Dr. Roy A. Wolford were reëlected Governors of the College for the U. S. Public Health Service and U. S. Veterans Administration, respectively.

Dr. Leonard G. Rowntree of Philadelphia was elected an Honorary Member at a meeting of the

Medical Society of the District of Columbia, June 19. In recommending Dr. Rowntree for such membership, the Executive Board called the Society's attention to his splendid record as Medical Director of the Selective Service System. While stationed in Washington, Colonel Rowntree took an active interest in the Society's activities and spoke at many of its scientific meetings.

Drs. Edward J. Stieglitz and Benjamin I. Weininger announce a special course of lectures on the subject, "Middle Age and Its Attendant Problems," beginning October 14. The course will consist of ten lectures, to be given weekly, on Monday nights, from 8 to 9 p.m. For further information regarding registration, telephone National 0894 or write the Executive Director, Washington School of Psychiatry, 1711 Rhode Island Avenue, N.W., Washington 6, D.C.

The course is a non-technical one for people concerned with problems of growing older, and is especially designed for nurses, educators, social service workers, clergymen, and also those mature individuals interested in making the most of their own later years. Problems to be discussed will include both the emotional and physical adjustments required by later maturity, including mental hygiene of middle age, learning, maintenance of interest and enthusiasm, nutrition in later life, living with a handicapped heart, abnormalities of blood pressure, and the climacteric. By informing their patients of the availability of this course, physicians can help their aging patients obtain the knowledge necessary for them to follow the doctor's specific instructions more intelligently. The course will adhere rigidly to the principle that no personal or individual advice will be given other than to seek diagnostic inventory and treatment from the person's own physician. The fee for the course is $15.00.

Dr. James A. Crabtree has been appointed **Deputy Surgeon General of the U. S. Public Health Service,** effective September 1, relieving **Dr. Warren F. Draper,** who has been assigned to the American Red Cross as consultant in medical and health services.

Dr. Draper has been Deputy Surgeon General of USPHS since 1939, was Assistant Surgeon General for 13 years beginning in 1922, and Virginia State Health Commissioner for 3 years. From May 1944 to September 1945 he was Public Health Chief at Supreme Headquarters, Allied Expeditionary Forces.

Dr. Crabtree, who has served as special assistant to Dr. Parran for the past year, was previously Deputy Director of Health for the United Nations Relief and Rehabilitation Administration. A graduate of the University of Tennessee School of Medicine, he received his postgraduate education in public health at Johns Hopkins University. He joined the Public Health Service in 1938, following a public health career in Tennessee. His last post there was as Assistant Health and Safety Director of the Tennessee Valley Authority.

At the meeting of the **Executive Board,** August 26, 1946, the following appointments were confirmed:

Dr. Henry C. Macatee, to succeed **Dr. Oscar B. Hunter,** as chairman of a committee to supply the Library of Congress with photographs of members together with biographical sketches.

Dr. Frank D. Costenbader to succeed **Dr. Daniel L. Borden** as Chairman of the Subcommittee on Prepaid Medicine.

Dr. William Earl Clark to succeed **Dr. Frank D. Costenbader** as Chairman of the Committee on Medical Care.

The September issue of the ANNALS listed the names of Medical Society members who were participating in the professional staff proceedings at **Walter Reed General Hospital** during the week of August 12. Programs for the following six weeks show other members of the Society appearing on these programs. They are Drs. Norman Q. Brill, Milton C. Cobey, Walter Freeman, James N. Greear, William H. Jenkins, Carlton N. Price, William J. Tobin, James W. Watts and Captain George Louis Weller.

Drs. Walter Freeman and James W. Watts presented a paper at the 21st Clinical Congress of the Connecticut State Medical Society and the Yale University School of Medicine, which was held in New Haven, September 10–12, 1946. Their paper was entitled "Prefrontal Lobotomy, 1936–1946."

Dr. Stephen E. Kramer informed the Medical Society's office that on August 1 he expected to assume his new duties on the staff of the Colorado State Hospital in Pueblo, and therefore found it necessary to resign his membership in the Society. His many friends will regret to learn of Dr. Kramer's resignation but will wish him success in his new position. He can be addressed at 1147 Longwood Avenue, Pueblo, Colorado.

Drs. Brooks G. Brown and Charles S. White, Jr., both recently released from active duty in the U. S. Army, are now at the Cleveland Clinic, also known as the Crile Clinic, in Cleveland, Ohio, where they have obtained fellowships in surgery.

Comdr. Wesley Fry informs the Society that he has reënlisted in the Navy and will be stationed at the United States Naval Hospital at Norfolk, Virginia. Dr. Fry was recently promoted to full Commander.

Dr. Robert F. Dow, former Major in the Army Medical Corps, was appointed Chief of Physical Medicine at **Veterans Administration Hospital.** He will also be in charge of rehabilitation at the hospital.

Colonel Wallace H. Graham, personal physician to President Truman, has been promoted to the rank of Brigadier General. The appointment is subject to approval by the Senate when Congress reconvenes.

Dr. Walter R. Stokes participated in a panel discussion on "Planned Parenthood and the Child" at the Seventh Annual Meeting of the Virginia League for Planned Parenthood, Inc., which was held on October 4 at the Jefferson Hotel in Richmond, Virginia.

Dr. A. C. Taylor of Washington was elected Honorary President of the **American Pharmaceutical Association** during its annual convention in August. Dr. Hugo H. Schaefer of Brooklyn and Dr. Robert P. Fischelis of Washington were reëlected Treasurer and Secretary, respectively.

BOOK REVIEWS

Pneumoperitoneum Treatment. ANDREW LADISLAUS BANYAI, M.D., F.A.C.P., F.C.C.P., Associate Clinical Professor of Medicine, Marquette University Medical School, Milwaukee, Wis.; member, Editorial Board, *Diseases of the Chest;* formerly Preceptor in Tuberculosis, School of Medicine, University of Wisconsin, Madison, Wis. Pp. 376, with 74 illustrations. Price, $6.50. St. Louis: Mosby, 1946.

The value of pneumoperitoneum in the therapy of tuberculosis has been the subject of great controversy among phthisiologists. Opinions regarding its use vary from rabid condemnation to almost overt indiscrimination. Dr. Banyai has long been a staunch advocate of this therapeutic method in the treatment not only of tuberculosis but of many other diseases of the lungs.

His text offers the reader a complete discussion of all the aspects of pneumoperitoneum. Section one deals with the basic principles of artificial pneumoperitoneum including technic of administration, physiologic and anatomic changes resulting from this form of treatment and complications. Section two covers the therapeutic application of pneumoperitoneum with emphasis on its use in pulmonary tuberculosis.

The indications for pneumoperitoneum offered by Dr. Banyai are somewhat broad and reflect his enthusiasm for this mode of therapy. However, most of the indications are sound and well supported by appropriate illustrative cases. No space is given to the importance of bronchial tuberculosis in the selection of methods of collapse therapy. No mention is made of the possible danger of pneumoperitoneum when used in the presence of this condition.

Pneumoperitoneum is offered by the author in selected cases of bronchiectasis and lung abscess. The inclusion of these conditions may make for completeness of discussion but detracts from the attractiveness of the volume.

Chapters on the use of pneumoperitoneum in tuberculosis, peritonitis and enterocolitis are included.

The book is well written, contains good illustrations, a complete bibliography and should be of value to the specialist in tuberculosis if properly scrutinized and evaluated in the light of latest developments in thoracic surgery and their effect on the indications for primary thoracoplasty and pulmonary resection.

S. K.

A Bibliography of Infantile Paralysis, 1789–1944, with Selected Abstracts and Annotations, prepared under direction of the National Foundation for Infantile

Paralysis, Inc. Edited by Morris Fishbein, M.D., Editor, *Journal of the American Medical Association;* compiled by Ludvig Hektoen, M.D., Chief Editor, *Archives of Pathology*, and Ella M. Salmonsen, Medical Reference Librarian, John Crerar Library, Chicago. Pp. 672. Philadelphia: Lippincott, 1946.

This is a complete bibliography of the literature on infantile paralysis, beginning with the first description by Underwood in 1769 and extending through the publications of 1944. There are over 6,320 titles, with selected abstracts and annotations. Carefully prepared author and subject indexes greatly facilitate the use of this volume. The book is well set up with clear print on good paper. It should be of great value to students of this disease.

Lewis K. Sweet, M.D.

A Guide on Alcoholism for Social Workers. Robert V. Seliger, M.D., Assistant Visiting Psychiatrist, John Hopkins Hospital; Instructor in Psychiatry, Johns Hopkins University Medical School; Medical Director, Haarlem Lodge, Catonsville, Md., and The Farm for Alcoholic Patients, Howard County, Md.; Executive Director, The National Committee on Alcohol Hygiene, Inc., in collaboration with Victoria Cranford, Psychotherapist and Rorschach Analyst, Haarlem Lodge, Director of Scientific Investigators, The National Committee on Alcohol Hygiene, Inc. Price, paper, $2.00. Pp. 94. Baltimore: Alcoholism Publications, 2030 Park Avenue, 1945.

This brochure contains a collection of papers by the author which he has read at various meetings or has previously published. Apparently no effort was made to edit the articles to avoid repetititon, so that approximately six pages of Chapter VII are a verbatim repetition of material contained in Chapter II.

In general, the medical social worker should find a great deal of valuable information in this series of articles, particularly in Chapter V, which contains excellent common sense, reëducational guides for the abnormal drinker.

John R. Cavanagh, M.D.

JOSEPH LAWN THOMPSON, M.D.

(1874–1946)

Dr. Joseph Lawn Thompson, Senior, an Active member of the Medical Society of the District of Columbia, died September 3, 1946, at his home, 1851 Columbia Road, N.W. Dr. Thompson had been in ill health for many years and was forced to retire from active practice several years ago.

A native of Washington, D. C., Dr. Thompson was born October 16, 1874, the son of Dr. and Mrs. Benedict Thompson. He was a nephew of the late Dr. J. Ford Thompson, well known surgeon in the District of Columbia. He spent his early years in Montgomery County, Maryland. The year following his graduation from Columbian Medical School in 1904, he began practicing in the District of Columbia.

JOSEPH LAWN THOMPSON, M.D.

Dr. Thompson served on the staff of George Washington University School of Medicine in many capacities, including Professor of Medicine. For many years he was Chief of Medical Service at Providence Hospital. Four years ago he resigned as Medical Director at Catholic University, which office he had held for 15 years.

In 1906 Dr. Thompson became affiliated with both the District Medical Society and the Medical Association of the District of Columbia. He held numerous offices in the Society, including chairmanship of the Executive Committee. For many years he held the office of Chairman of the Hospital Committee. As a member of the special Medical Practice

Act Committee, which was appointed in 1929 when the Healing Arts Practice Act was under consideration, he was among those instrumental in securing the passage of the present Act. He was also the author of many scientific articles.

He is survived by his wife, Mrs. Anna Waters Thompson; two sons, Dr. J. Lawn Thompson, Jr., who is engaged in the practice of medicine in Washington, and Lt. Comdr. Charles Waters Thompson, who is stationed at the U. S. Naval Medical Center, Bethesda, Md.; and a daughter, Mrs. Howard Coppenbarger, Cleveland, Ohio. He also leaves a sister, Miss Noma Thompson, Washington, and a half-brother, Edward Anderson, of Los Angeles, Calif.

DR. J. LAWN THOMPSON: AN APPRECIATION

On September 3, 1946, Dr. J. Lawn Thompson closed his eyes after five years of inactivity due to ill health and went to his reward. Lawn was a red-headed, fiery individual, always mentally and physically active, quick at repartee; devoted to his patients and his friends, soft-hearted and charitable in his judgment of others. He gave of his energy and knowledge without financial reward to many patients, often paying for their prescriptions and sometimes for their food.

I got to know him intimately in 1914, although I met him about 1907, shortly after we began the practice of medicine. In 1914 we were appointed to the same Physicians' Board of Pension Examiners (the other member was John Van Rennslaer). The Board met at Dr. Thompson's office twice each week, where for ten years we cemented a lifelong friendship. There, between examinations, we swapped stories and experiences and were frequently called by our intimates "The Three Musketeers."

Lawn enjoyed a large practice, including about 40 per cent clergy whom he never charged. Add to this the 10 per cent charity patients which all doctors serve, and we find that 50 per cent of his energy was expended without compensation. He referred his surgery to me for twenty-five years and, while the volume was great, there were, of course, many cases done for the love of God.

Characteristic of Lawn is the story he told about his first day in practice. He had just invested the last of his funds in an office sign and was hopefully waiting to be convinced that it could be seen from the street. A man walked in and asked him if he treated throats. Lawn said he did and that the fee would be two dollars. The patient said, "I can go around to Connecticut Avenue and have Dr. Charlie Richardson treat me for that fee." "Yes," said Lawn, "but you can get extra service here. You can sit in the chair after your treatment until tomorrow morning, if you like." That man was a regular patient afterwards.

Lawn's uncle, J. Ford Thompson, was Washington's first surgeon.

Shortly after beginning practice, Lawn submitted to a gastroenterostomy for ulcer. The symptoms were not entirely relieved. This, plus a bronchiectasis which persisted throughout his life, would tend to slow up another man; not so Lawn, who assumed his load and carried it for many years. He became physically exhausted at times and he would be irritable and short-tempered. He always regretted these outbursts, and when he was rested, he became his old cheerful, amiable self again. His hobby was fishing and he spent part of most years in Florida, where he indulged in the deep sea sport. He collected valuable fishing paraphernalia, which he loved to display to his friends, entertaining them the while with anecdotes of his trips. He was a frequent contributor to medical publications. He constantly improved his diagnostic acumen by special courses at various clinics throughout the country. He was honored at home by holding important offices in the Medical Society, by serving as Chief of Medicine at Providence Hospital, and as Chief Medical Officer at the Catholic University.

He was justly proud of his fine family. Mrs. Thompson was an ideal doctor's wife, whose kindness and diplomacy attracted patients. Both of his boys became doctors. During World War II, his son Lawn served in the Army, and Charlie in the Navy. Lawn, Jr., is making a good reputation in Washington as an internist, and Charlie will soon return to practice internal medicine. His daughter is happily married and lives in Cleveland.

Many people mourn the loss of this good doctor, fine friend, and Christian gentleman. I, personally, do not hope to meet a more interesting and likable character.

JAMES A. GANNON, M.D.

September 4, 1946

CLINE N. CHIPMAN, M.D.

(1884–1946)

Dr. Cline N. Chipman, well known anesthetist of Washington, where he had practiced for 38 years, died at his home, 1420 Rhode Island Avenue, N.W., September 7, 1946. He had been ill for several months.

Dr. Chipman was born in Falmouth, Kentucky, May 20, 1884. He graduated from George Washington University School of Medicine in 1907 and began practicing in the District of Columbia the following year. He was Associate in Anesthesiology at George Washington University School of Medicine, where he had taught for more than 25 years. He was also Associate in Surgery at the University Hospital and on the staffs of Emergency and Gallinger hospitals.

During his Active membership in the Medical Society of the District of Columbia, which extended from 1910, he assumed responsibilities which were often time-consuming. Particularly was this true while Chairman of the House Committee, which office he held for many years. During his chairmanship Dr. Chipman visited the Society's offices frequently and took a paternal pride in seeing that the building was properly equipped and renovated from time to time.

Dr. Chipman held membership in the International Association of Anesthetists, was a Fellow of the American Medical Association, and a member of the George Washington University Medical Society. He also held membership in many civic, fraternal and social organizations, including the Washington Board of Trade, the Masonic Order, and the Congressional Club. He was affiliated with the First Baptist Church.

His wife, Mrs. Mary H. Chipman, who resides at Auburndale, Fla., survives him, together with a son, Cabell D. Chipman, of Lakeland, Fla., a daughter, Miss Katherine P. Chipman, of Washington, and a stepdaughter, Mrs. Martha Carr, of New York City.

JOHN JOSEPH SHUGRUE,

A.B., B.S., M.D.

(1893–1946)

Dr. John Joseph Shugrue, neurosurgeon, died September 17 at Emergency Hospital, following an illness of more than a year. He resided at 2123 Leroy Place, N.W.

A native of the District of Columbia, Dr. Shugrue graduated from Georgetown Preparatory School and Georgetown University, receiving the degrees of A.B. in 1915, B.S. in 1917, and M.D. in 1919. After practicing surgery for several years, he obtained a fellowship in neurosurgery at the Mayo Clinic in Rochester, Minn. Following three years of study at the Clinic he returned to Washington and limited his practice to neurological surgery. He also resumed his academic relations with Georgetown University, this time as a member of the faculty of the School of Medicine with the title of Professor of Neurosurgery.

The Shugrue drill, which he invented, has cut almost in half the time needed to perform brain operations.

Prior to World War II he served as civilian consultant to the Army on neurosurgery, performing operations at Walter Reed Hospital. Although he resigned this post, he continued to serve in an advisory capacity to the Army Medical Corps until his last illness. He was also neurosurgeon on the staffs of Doctors, Emergency, Providence, Gallinger, Georgetown and Columbia hospitals.

Dr. Shugrue was elected an Active member of of the Medical Society of the District of Columbia in 1929. He was a Fellow of the American Medical Association and a Past President of the Osler Society. He was also a member of the Metropolitan Club.

Surviving are his wife, Mrs. Margaret Moran Shugrue; two stepdaughters, Mrs. John E. Murdock, Jr., and Mrs. Allen Manning; and a sister, Mrs. Patrick Madigan, all of Washington.

Federal Hospital Council

(Continued from page 511)

business, etc. Among them were Dr. Claude Munger, Medical Director of St. Lukes Hospital, New York, who assisted the Washington Metropolitan Health Council in its recent hospital survey; Dr. Victor Johnson, Secretary, Council on Education and Hospitals, American Medical Association; George Bugbee, Executive Director, American Hospital Association; and Dr. Franklin S. Crockett, Chairman, Committee on Rural Medical Service, American Medical Association; and from Washington, D. C., Nelson Cruikshank, Director, Social Insurance Activities, American Federation of Labor; Mrs. Agnes E. Meyer of the *Washington Post;* Right Reverend Monsignor John O'Grady, Secretary, National Conference of Catholic Charities; and Miss Elisabeth Christman, Secretary-Treasurer, National Women's Trade Union League of America.

The allotment figures to the states for the five-year hospital construction program authorized in the Act were released August 21 by Surgeon General Parran. The Act authorizes the appropriation of $3,000,000 for statewide hospital surveys and for planning of construction programs, and $75,000,000 annually for five years for the actual construction of hospitals and related facilities. Of these amounts authorized, only $2,350,000 has been appropriated to date. This is earmarked for assistance to states in surveying and planning and for administrative expenses of the U. S. Public Health Service in connection with this program.

The share to which each state is entitled from the $3,000,000 appropriation for survey and planning expenses is based on state population. For determination of the distribution of the $75,000,000 authorized for construction, a formula is used which takes into consideration both the population and the per capita income of each state. Preliminary estimates show the allotment for the District of Columbia to be $19,145 for survey and planning and $298,350 for construction purposes.

A newly formed Division of Hospital Facilities in the U. S. Public Health Service, to be headed by Medical Director Vane M. Hoge, will be responsible for carrying out the advisory functions which the U. S. Public Health Service will perform in accordance with the provisions of the Act.

Washington Physicians of Yesterday-Tyler

(*Continued from page 515*)

Dr. Tyler was a member of the Protestant Episcopal Church. In January, 1836, he married Mary M., daughter of Walter Bowie. His death occurred August 26, 1884.

Dr. Tyler was succeeded in his chosen profession by his son, Dr. Walter Bowie Tyler (1846–1889), and by his present great-grandson, Dr. Grafton Tyler Brown, both active physicians in Washington and members of the Medical Society.

JOHN B. NICHOLS, M.D

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QUESTIONS OF CURRENT INTEREST IN THE SWEDISH MEDICAL WORLD

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Medical research, like all other branches of intellectual activity in Sweden, has, of course, benefited from the fact that Sweden escaped being drawn into the maelstrom of the war. The work at laboratories and clinics has gone on undisturbed, although naturally it has suffered to a certain extent from the lack of contacts with medical researchers in so many countries.

The object of the present article is to endeavor to describe briefly some of the most interesting results achieved during and subsequent to the war years and in conclusion to say a few words on administrative problems connected with research in Sweden.

Chemistry, Physiology and Cytology

The oxidation ferments (particularly the hemoproteins, catalase, peroxidase, and verdo-peroxidase) have been studied by H. Theorell and his co-workers.

The distribution of nucleic acid in the different organs has been made the subject of study by E. Hammarsten, and quantitative methods for separating ribopolynucleotides and desoxyribopolynucleotides have been worked out.

At the Institute for Cytologic Research in Stockholm, with T. Caspersson at its head, a series of investigations on the structure of the cell nucleus in different animal and plant cells, tumor cells, and bacteria have been carried out, the technic used being based on the light absorption of the nucleic acids in U.V.

The formation of aseptic urinary calculi, particularly oxalate calculi, has been made the subject of experimental studies by Greta Hammarsten, who found that magnesium deficiency in animals causes an increase in the amount of oxalic acid secreted with the urine. She was able to reduce the oxalic acid secretion to a minimum both in rats and in human subjects by supplying an adequate amount of magnesium. In experiments with ethylene glycol in which the oxalic acid formation in the organism increased, the increase was found to occur both when the supply of magnesium was good and when there was a magnesium deficiency. The prophylaxis is of the utmost importance, namely, an adequate diet (with plenty of coarse bread, milk, fruit, and vegetables), which will furnish the necessary quantities of the essential minerals (especially calcium and magnesium) and of the vitamins required for metabolism. In the case of small renal calculi (oxalate calculi), it seems to be possible to counteract enlargement of the calculus by adding magnesium to the diet, while in the case of larger calculi, especially compact ones with a smooth surface and having a shape making passage difficult, surgical measures should be adopted. If the calculus is not compact and the patient is in good general condition (there must be no infections), an attempt can be made to disintegrate the calculus by dietetic treatment before an operation is undertaken.

Ahlmark has demonstrated that there is a characteristic rise in the histaminase content of the blood during pregnancy, starting in the seventh week and reaching a maximum (about one thousand times higher than the normal content) in the seventh month. On the basis of this observation a reaction has been worked out which has been found to have practical diagnostic significance when imminent abortion is suspected, since a decreasing histaminase content is an expression of the fact that pregnancy has been broken off.

It has been observed (by U. von Euler) that piperidine occurs in the urine as a substance (probably identical with urohypertensin) producing a rise in blood pressure and with a nicotine effect even in non-smokers. An amount of 10 mg., with a nicotine effect of 0.5–1.0 mg., is normally secreted daily.

As is well known, the majority of the organs (especially the spleen) contain a substance, sympamethine, having an effect similar to that of epinephrine. The substance in question can be differentiated biologically and chemically from epinephrine, resembling nor-adrenalin (arterenol) in these respects. Von Euler therefore considers that the sympamethine is nor-adrenalin, which is formed along the entire length of the adrenergic nerve fibers.

Hypertensin has been prepared in pure form by P. Edman and found to be a polypeptide with an approximate molecular weight of 3,000 and an isoelectric point at pH 6.8. With respect to the blood pressure-increasing effect it is equivalent to the same amount in weight of epinephrine.

Y. Zotterman has published a number of papers on the peripheral sense impulses and their conduction in the nerves, and at the Institute for Neurophysiology, of which Granit is the head, a special study has been made of the electrophysiology of the retina.

In Lund, investigations on the physiology of the gastric secretion have been carried out by G. Kahlson and collaborators. Uvnäs, for instance, has made a study of gastrin. Histamine in the blood has been studied by Emmelin, and the physiology of the muscular contractions has been reviewed by Lundin. Abdon has studied in detail the acetyl choline precursor and its role in the muscular contraction.

From Upsala valuable reports have been made by N. Törnblom, among other researchers, who has studied the hormone production of the testes and the relation between this and the anterior lobe of the hypophysis, and also by H. Forssman, who has made a survey of our present knowledge on hereditary diabetes insipidus. In the last mentioned publication Swedish families with diabetes insipidus were followed through several generations. Three different forms of the disease are described.

Bacteriology and Virology

The investigations carried out by S. Gard, partly in coöperation with A. Tiselius at Upsala, on the purification of the poliomyelitis virus, have attracted much attention. His studies resulted in the production of a pure virus from infected mouse brain, in all probability closely related to the human virus obtainable from infected spinal cord in man. Gard considers that the virus is very probably not neurotropic to start with but that it can acquire this characteristic under certain circumstances.

Intensive research work on antibiotics has been carried on in Sweden, as in many other countries, during the past few years. Penicillin has not yet begun to be produced in Sweden, but there is a good supply of penicillin in the country at present, thanks to imports from the United States of America. At the Central Municipal Bacteriological Laboratory in Stockholm and the Medical Nobel Institute, H. Davide, H. Theorell, and S. Bergström are working intensively on experiments to isolate the factor inhibiting the growth of the tubercle bacillus in various bacteria, especially *B. pyocyaneus* and *B. proteus*.

RESULTS OF VALUE IN CLINICAL PRACTICE

Internal Medicine.—A report on hemophilia in Sweden has been published by E. Sköld, who made an inventory of the total number of hemophiliacs in the whole kingdom (100 among a population of 6.3 million). There are about 50 sure or probable conductors. A large number of cases have been successfully treated by regular blood transfusion, this having proved to be the only effective therapy. Eugenic measures in the form of voluntary sterilization and abortion are being planned with a view to reducing the number of hemophiliacs and conductors.

The chemistry and physiology of heparin was cleared up in Sweden about 10 years ago by E. Jorpes, who demonstrated in collaboration with H. Holmgren and O. Wilander that heparin is the metachromatic granular substance in Erlich's mast cells of the connective tissue which form a physiological hormonal system. During the past 5 years heparin has been widely used in the treatment of thromboembolism. The first to begin using heparin in clinical practice was Cl. Crafoord, at the surgical clinic of the Sabbatsberg Hospital. G. Bauer, at Mariestad, has also shown much interest in heparin treatment. For the past 5 years he has been treating all cases of thrombosis and pulmonary embolism at an early stage with heparin and movement therapy. Only 3 out of 209 patients died, and the average length of the stay in hospital was 4.7 days. Among the 264 untreated thrombosis patients from the preceding 10-year period 47 died, and the hospital stay on account of thrombosis was on an average 40 days. Heparin has also proved to be very valuable in the treatment of pneumonia cases not responding to sulfa therapy and in mesenteric vein or cavernous sinus thrombosis. In the case of cavernous sinus thrombosis heparin has been used in combination with sulfa drugs and penicillin.

Treatment with the anticoagulants heparin and dicumarol, in conjunction with early ambulation after surgical procedures, has yielded excellent results in Sweden. Zilliacus, in 1946, found at 20 Swedish hospitals, in addition to Bauer's cases, 679 cases of deep venous thrombosis or pulmonary embolism the majority of which had been treated with heparin and the rest with heparin and dicumarol or with the latter agent alone. The stay in hospital was 8–10 days, and 3 deaths occurred. Among 277 conservatively treated cases for the same period at these hospitals 41 died, and the average length of the hospital stay on account of thrombosis was 35 days. Reports by Swedish physicians (Birger, Bauer) have also established that in at least 40 per cent of all cases, possibly much more, chronic leg ulcers and indurative lesions are the aftermaths of a deep venous thrombosis from which the patient has previously suffered. It has been found that these can be prevented if the patient is effectively treated with heparin while the thrombotic process is still confined to the lower part of the leg. When heparin treatment is given at an early stage the process does not progress further than the calf; if the treatment is delayed it progresses up into the thigh and destroys the femoral vein in 80 per cent of the cases. Dicumarol is also used extensively with good results, in cases in which this form of the treatment is suitable. A number of papers have been published on dicumarol therapy (see Bruzelius). The social consequences of the introduction of this new therapy are considerable, namely, a decrease in the mortality, reduction of the stay in hospital, and no subsequent invalidity.

Pediatrics.—In the pediatric field the rearing of premature infants is a problem which has received the attention of Swedish investigators also, and has led to the introduction of a new principle for treatment. It has been found that an amount of 2.5 Gm. of amino acids per Kg. of body weight given as an additional food to breast milk accelerates growth to a very considerable degree. There is a gain in weight of 30–35 Gm. a day in most of the infants given this treatment, and the time required in the hospital for prematurely born infants has consequently been shortened by about 40 per cent. This fact is also an advantage from the aspect of reducing the mortality in infective diseases. The most underdeveloped infants, with a birth weight of 1,300–1,500 Gm., show the best weight increases (Magnusson, Jorpes and Wretlind, *Lancet* 1946). The amino-acid mixture, which is available under the trade name of Aminosol, is an enzymatic casein hydrolysate purified by dialysis. The purified preparation can be administered by intravenous infusion and can be given in conjunction with glucose, sulfa compounds, penicillin, and heparin, the effect being good in many complaints, among others cholera infantum (H. Magnusson).

While on the subject of Swedish drugs produced in our factories during the war, mention can be made here of sulfathiazole (Laudon and Sjögren) and sulfapyridine (sulfadimin), the good effects of which have been described in a number of publications; they have held their own well in competition with the international preparations.

A number of cases of renal damage have been reported from various quarters after treatment with sulfa drugs, and it has proved an extremely difficult matter to prepare a compound which will eliminate these risks. The Swedish drug manufacturers, Astra, have recently put on the market, on the suggestion of G. Hagerman, a preparation consisting of a combination of sulfanilamidothiazole, sulfanilamidopyrimidine, and sulfanilamidomethylpyrimidine (called Sulfadital), which, owing to the lower concentration of the different components, lessens the risk of concretion formation in the kidneys when administered in the usual manner together with sodium bicarbonate or sodium citrate.

Surgery.—Developments in Swedish surgery have taken place notably in the thoracic field, through the lung and heart operations performed by Crafoord. Crafoord has developed the technic for lobectomy to a considerable extent, having worked out his own method for effectively supporting the bronchus stump, which, as is well known, is the leading problem in this operation. Great interest has also been evinced in Crafoord's operations for patent ductus arteriosus and congenital coarctation of the aorta. All cases of patent ductus arteriosus encountered have been operated upon, a total of 62, between the ages of 3 and 29 years. The patients were operated upon under general narcosis (cyclopropane, nitrous oxide, and oxygen), with the aid of the spiropulsator described by Crafoord, Frenckner and Andersson. Crafoord used the large S-shaped incision which he employs for other major interventions on the thorax, resecting the fifth or sixth rib from the chondrocostal articulation to the angulus costae. Double ligation was used in patients in whom the ductus was relatively long and narrow. In other cases the duct was divided and the stumps supported by vessel sutures. In 4 instances the condition was complicated by endarteritis and sepsis, and these patients were treated both preoperatively and postoperatively with sulfathiazole and penicillin. Of the 58 non-infected patients 1 died, and 1 of the infected patients also died.

The operation for coarctation of the aorta, which no surgeon before Crafoord would take the risk of performing, was tried for the first time in October 1944, and subsequently has been performed successfully in 7 out of 8 cases. The incision and method of producing anesthesia were the same as for the ductus arteriosus operations. The coarctation was found to be at the same level as Botallo's duct, and in 1 case there was even a persisting Botallo's duct. After shutting off the aorta both above and below the constricted area, this segment was resected, its lumen having been found to be extremely small, from the thickness of a match to that of a stocking knitting needle. After the resection the stumps of the aorta were approximated end to end, 3 interrupted sutures being placed at equal distances from one another, and then running silk sutures sewn between the interrupted sutures, taking in adventitia, media, and intima, in the latter so superficially that the suture material was nowhere inside the lumen of the aorta. The blood pressure and pressure amplitude were beautifully registered both before and during the operation on an oscillograph designed by Ejrup.

Intussusception, which is a subject of dominant interest in the field of children's surgery, has been studied by Nyborg, who has advanced as a possible explanation of its genesis the view that the endogenous intussusception-provoking factor may be a disturbance of the balance in the autonomic nervous system. The endogenous factor causing intussusception can be a tumor or the equivalent of a tumor, e.g., an intestinal diverticulum, or a chronic gastric ulcer, but in most cases it consists, according to Nyborg's experience, in a prolapse of the terminal portion of the ileum into the colon. The prolapse arises as the result of disturbances in the vegetative balance of nervous origin. With regard to treatment Nyborg draws attention to the absolute necessity for individualization. Children with severe meteorism, with suspected peritonitis, or a badly affected general condition, should be operated upon primarily, without any preliminary attempt at reduction under X-ray control. All other children, irrespective of the point of time when they fall ill, should be given a contrast lavage with a view to causing reduction. If this is unsuccessful, or if there is any doubt as to its effect, the child should be operated upon as a secondary measure (disinvagination as far as possible, since resection has proved to be very dangerous). The results achieved at Kronprinsessan Lovisa's Children's Hospital in Stockholm during 1935–1941 were very promising. Reduction was obtained by contrast lavage in 53 per cent of the cases. In the author's material the mortality was only 4 per cent among the infants, and among older patients there were no deaths. In material treated strictly conservatively the total mortality (with the exception of the few resection cases) was found to be 6 per cent, in material treated by surgery as the primary measure 20 per cent, and in the series at the above-mentioned hospital 2.5 per cent.

Gynecology. The well-known hormone researcher, A. Westman, has devoted a great deal of time to the treatment of sterility. Westman considers that the results at present obtainable in the curing of sterility lie between 30 and 40 per cent. He has also introduced improvements in the treatment of sterility in women, especially as regards damaged adnexa due to inflammation. Chemotherapeutic therapy should be applied in connection with the operation in order to endeavor to avoid a latent infection from flaring up and causing new adhesions. It is of great importance to know whether the passage through the tubes is free or not during the course of the operation, and in order to be able to judge the result of a plastic reconstruction of a fallopian tube Westman has worked out an insufflation method which has proved to be extremely valuable. A puncture needle connected with an insufflation apparatus is introduced through the wall of the uterus, and with the aid of this needle it is possible to insufflate an exactly regulated amount of carbon dioxide. The cervical canal is shut off with a special forceps. When the passage through the tubes is clear, the gas bubbles out through the ostia and forms a foam around them. In the case of an obstruction the tube becomes distended on the uterus side of the obstruction, with the result that the constricted, or perhaps completely blocked, segment can readily be localized. Another difficult problem is to prevent a newly made ostium from adhering. Westman has endeavored to prevent this by inserting into the ostium a small plug of stearin with a melting point of 38–39°C. When it is estimated that the healing process is completed the patient is given a diathermy treatment, until the temperature rises to 40–41°C.; the plug then melts and the tubes are flushed out with a warm fluid in order to remove the stearin completely. When once it has been washed out into the peritoneal cavity it can soon be absorbed. After the operation the patient is given a treatment with estrone, since it has been found that the motility of the tube is stimulated by the hormone.

ADMINISTRATIVE AND FINANCIAL QUESTIONS

Medical research in Sweden is aided to a very large extent by contributions from private donation funds, and the sums hitherto at the disposal of research workers have been far from adequate in meeting the demands. During the Parliament of 1943 a motion was passed to permit the institution of a State Advisory Board for medical research. This began to function in 1945, with representatives from the medical faculties, from research workers outside the faculties, from the exact natural sciences, odontology, and veterinary medicine, under the presidency of the Chancellor of the universities of the kingdom and with the head of the State Medical Board and the Physician-in-Chief of the Defence Forces as *ex officio* members. The Medical Research Board, which together with the three medical faculties has had the sum of 1,000,000 Swedish crowns from the State funds placed at its disposal, is to give financial support to extensive scientific investigations and to assist individual research workers. It is to be hoped that through its activities the team-work principle in scientific research which in contrast to the Anglo-Saxon countries is so little practised in Sweden will gain ground and have a stimulating effect on experimental medicine.

During recent years new fields of activity have been opened up for medical men in Sweden, where hygiene and the care of the sick are in the process of being greatly expanded. At least 100 new medical posts were made available during 1945 in Sweden, a welcome addition above all to the younger physicians. There is an annual increase of 150 new physicians in Sweden. Among the new fields now opening up for physicians desiring to specialize, mention may be made here of vocations as clinical laboratorians, anesthetists, specialists in social diseases, professional hygienists, industrial hygienists, children's surgeons, thoracic surgeons, plastic surgeons, legal psychiatrists, and pediatric psychiatrists. There is thus no lack of avocations for a nation desiring to keep abreast of developments in the medical world as in all other branches of cultural life, and to the extent our resources permit we Swedish medical men are anxious to continue working purposefully both on theoretical and practical problems in all the many fields of medicine.

REMOVAL OF SUPERFLUOUS HAIR BY MONOPOLAR COAGULATION

MURRY M. ROBINSON, M.D.

Washington

THE presence, or absence, of hair on various parts of the body is a fashion which varies in different parts of the world and in the same areas over a period of centuries. These fashions are governed by religious laws or aesthetics. One religious group makes the wearing of beards mandatory, at the same time prohibiting the wearing of a mustache. Another group insists that the lock of preauricular hair shall never be cut. There are some primitive groups which insist on the removal of all pubic hair and others which sacrifice the eyebrows, and even the eyelashes. What is now considered superfluous in our present civilization may have been considered essential adornment in the past. It is uncommon to see a beard today, yet not so very long ago beards of all descriptions were the height of fashion. Men, not satisfied with their own crop of crowning glory, added long curled wigs to supplement their own scarcity. Even in women there have been distinct fashions in the presence or absence of what we now call superfluous hair.

Women for many years have considered hair on the face an unwanted nuisance, but with the emphasis on glamor in the last 20 years the removal of hair from the face is becoming imperative. The requests for such removal of dispensable hair are increasing. Where the original concern was for the removal of facial hair, now it has expanded to include removal of hair on eyebrows, breasts, axillae, abdomen and legs. Now that women are wearing abbreviated sports and bathing costumes, the hair that is present in some of these latter areas is a disfigurement which many women want removed.

Occasionally one gets requests for the removal of hair on the forehead to change the shape of the hair line. One must exercise great caution in removing hair in this location. The hair follicles are very close together, and the destructive processes may so run into each other that large necrotic areas may be formed and result in visible scarring. In addition, the new hair line may look quite artificial and the end result will, in general, be unsatisfactory.

Removal of hair from the covered parts of the body does not present any greater difficulties than removal of facial hair. I am of the opinion, however, that unless there is some definite psychogenic factor involved the removal of hair in those areas should not be done by a physician. The use of depilatories to remove hair from the legs or other covered parts of the body is a simpler and less expensive method.

Hypertrichosis in women is not purely a cosmetic problem. The concern and emotional discomfort it causes varies from mild discouragement to emotional derangements and can give rise to psychosomatic symptomatology of severe nature. The embarrassment caused by the presence of these beauty-detracting hairs may seriously hamper a woman's social activities. A girl, 18 years of age, who suffered from severe headaches and edema of the eyelids which occurred especially when guests were coming to her house or when she was supposed to go out among people, lost these symptoms when the hair on her face was removed by electrolysis. This is an isolated case, but many similar cases probably come under the observation of general practitioners and specialists who do not often associate the symptoms with the unwanted hair.

The methods of removing superfluous hair are many. Tweezing is, of course, the easiest and most frequent method used. There is hardly a woman alive who has not tweezed out unwanted hair. It is a fairly satisfactory method in locations where the hair is sparse, but when it is abundant the method is laborious and not too satisfactory. Chemical depilatories and waxes offer the same advantages and disadvantages as tweezing. The waxes are painful to use and the chemical depilatories often cause a secondary dermatitis. X-ray treatment to remove hair is only mentioned to condemn it, since its use results in X-ray changes in the skin. The use of pumice stone is an excellent method of temporarily removing the hair from the legs but is not well tolerated on the face. This method is extremely popular among show people, many of whom claim that continued use actually causes atrophy of the hair.

The standard method for the local treatment of hypertrichosis has remained essentially unchanged for 60–70 years. This method is negative galvanism, using a needle electrode carrying negative galvanic current generated by batteries. The machines in use by dermatologists and electrologists in beauty salons vary primarily in the external adornment of the machine and the number of needle electrodes used. The dermatologist's machine is usually a simple affair with energy derived from $22\frac{1}{2}$ to $67\frac{1}{2}$ volt "B" batteries supplied with a positive electrode to which is attached a wet sponge which the patient holds in close contact to her skin, and a negative needle electrode of fine gauge steel or platinum. Inserted into the circuit is a milliammeter and a rheostat to control and measure the current. The larger and more handsome machines used in beauty parlors are of the same construction in their essentials but are usually embellished with eye-pleasing gadgets and frequently use multiple negative needle electrodes so that more than one hair can be treated at one time. The number of needles vary from 4 to 12. With these multiple needle machines, operators rarely use all of the needles, limiting themselves to about 4 as an average. The needles are inserted into the hair follicles until the point touches the papillae and left there until a bubble of fat appears at the opening of the follicle. The hair is then tested for looseness with a forceps and if the operation is complete, the hair will slide out of the follicle without resistance. The length of time necessary to destroy a hair varies from 30 seconds to 2 minutes with the average time about 1 minute. A pin-point erythema is usually left at the follicle opening which becomes covered with a tiny scab. This remains for about a week or two and then disappears.

One can easily see that this method is extremely slow and tedious. In addition, the red pin-point marks which form after each operation are undesirable. A faster method and one which does not produce these red points would be an improvement. The use of high frequency current for the local removal of hair is not a new idea. It was presented in 1924[1] but made very little progress. The reason for the lack of progress was the inadaptability of the equipment which was available at that time. It was true that this method was more rapid, but it produced pin-point scars which caused a pebbled appearance of the skin if the hairs removed were numerous and closely packed. Dermatologists who wished to use this method because of its rapidity abandoned it for the more reliable, less scar-producing, if slower, method of negative electrolysis.

Karp,[2] in 1941, working with a new apparatus which was capable of fine adjustment, claimed excellent results with a bipolar method of diathermacoagulation. She felt that her results were superior with this method to that with the galvanic current. She was able to treat about 4 times as many hairs. In addition, the after irritation of the skin was practically nonexistent. This indeed was a great improvement in the treatment of hypertrichosis. It still had a few faults; although the method was extremely rapid, some scarring was still produced.

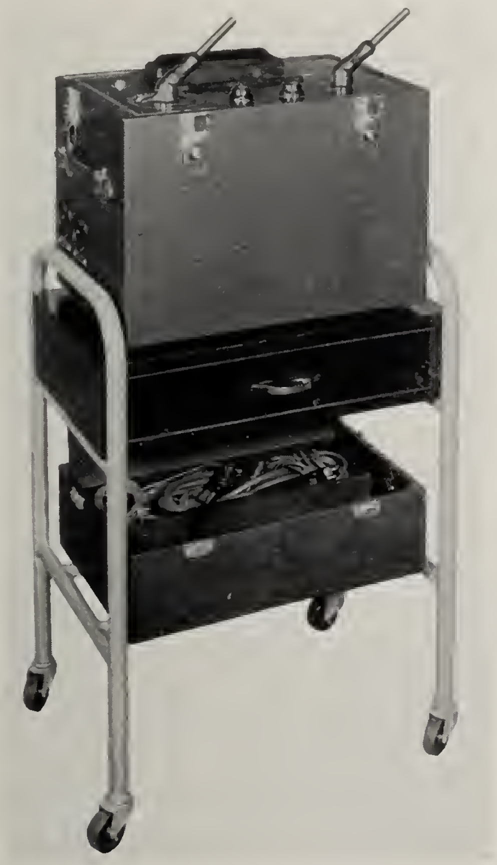

FIG. 1. Monopolar coagulation apparatus for treating hypertrichosis.

Lerner,[3] in 1942, used a similar machine with similar technic and also found it superior to negative electrolysis in every respect. These methods, although far superior to the old method of negative galvanism, still left something to be desired. It was still necessary to find some method which produced less scarring and was in addition rapid and relatively painless. I have been experimenting with a new needle which is simpler, more effective, just as painless and rapid, and less destructive of the surrounding tissue than the method in standard use.

DESCRIPTION OF APPARATUS

The equipment consists of a spark-gap machine which generates a highly damped high-frequency current, oscillating at a frequency which averages 30,000 to 40,000 wave trains per second. It is the same type of machine which is normally used for surgical diathermy.

The current is delivered at the papillae through a fine platinum irridium needle placed in a chuck handle at an angle of about 45° so that the chuck handle can be held in much the same manner as a pencil (figures 1, 2 and 3).

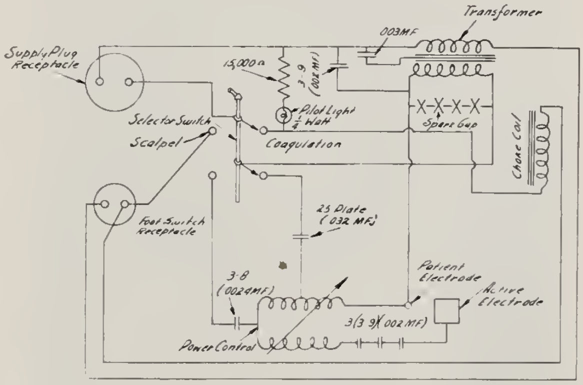
Transformer
003MF
Supply Plug Receptacle
15,000 Ω
3-9 (002 MF)
Pilot Light ¼ Watt
Spark Gap
Selector Switch
Scalpel
Coagulation
Choke Coil
25 Plate (032 MF)
Foot Switch Receptacle
Patient Electrode
Active Electrode
3-8 (0024MF)
3(3 9)(002 MF)
Power Control

FIG. 2. Schematic diagram of unit for epilation with monopolar coagulation.

TECHNIC

The usual precautions are followed with this method as with all other methods of local hair removal. The surface of the skin should be thoroughly washed with soap and water followed by alcohol, and either wiped dry with a sterile sponge or allowed to dry in the air. The needle and forceps used should be soaked in alcohol or other instrument-sterilizing solution for 10 minutes prior to use.

The patient is placed on a table or on an adjustable chair. I have found that a dental chair is more comfortable, both for the patient and the operator. The best source of light is an artificial spotlight. The patient's eyes should be covered so that the light does not shine into them. The needle is slipped into the follicle along the course of the hair until some resistance is felt. Usually this is about 3–5 mm. With the needle in the follicle the current is turned on in bursts by means of a foot switch, each burst of current lasting a fraction of a second. The number of times the current is turned on varies with the thickness of the hair. Above the upper lip 1 to 3 times is usually sufficient to destroy the papilla, and on the chin 4 to 6 times is necessary. If the hairs are especially coarse, more bursts may be necessary. There is no hard and fast rule for this, but the number of bursts necessary to destroy the hair is easily ascertained after the first treatment on each patient. The hair is tested by pulling it gently with a forceps. When the papilla has been destroyed, the hair will slide out of the follicle without offering resistance. As a rule the pain is minimal. I have had only 1 patient in all of those treated complain. Faulty technic, however, does produce some pain. If the needle pierces the follicle or is not inserted deep enough the pain will be greater. In addition, if the point of the needle is too close to the surface, a spark may jump, producing a desiccation type of reaction. This will not only produce a burning sensation, but the surface of the skin at the follicular opening will be charred. Other than these factors the method is almost devoid of discomfort.

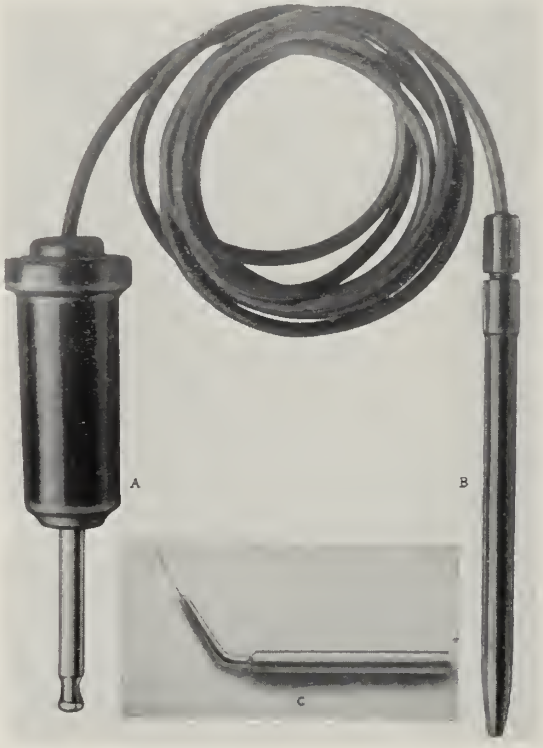

Fig. 3. (A) Adaptor to regulate the current on the apparatus so that at a given setting the current is always the same; (B) needle holder; (C) specially designed angulated needle electrode.

Although the same apparatus can be used for Karp's bipolar method and for my method of monopolar coagulation, there is a difference which should be explained. Using the monopolar method, the amount of current used, on the smallest setting of the power dial, is less than it would be on bipolar coagulation using the same setting. This smaller amount of current is sufficient to destroy the hair, yet it is not great enough to cause significant destruction of the surrounding epithelium so as to produce noticeable scarring. Having had some experience with the bipolar method, I was impressed with its superiority over the method of negative galvinism. It produces fewer scars and is more rapid. Some slight scarring, however, was produced which led me to experiment with smaller currents. The monopolar method seems to me to be just as rapid as the bipolar process and leaves less scarring because of its finer spark.

There is a definite reason for the use of many short "bursts" of current rather than current applied continuously. When the current is first turned on the discharge action occurs at the tip of the needle; as the application of the current is continued, it spreads up the shaft of the needle. The "coagulation" forms a cone with the apex at the point of the needle and the base at the surface of the skin, so that with a steadily applied current, destructive action will occur at the skin surface and produce visible scarring; whereas with the current applied in short bursts the action takes place only at the papilla and its immediate surroundings, and the surface of the skin is left unaffected.

HISTOPATHOLOGY

Hairs were removed from the flexor surfaces of the forearm of a donor by 3 methods: (1) negative galvanism, (2) monopolar coagulation, and (3) Karp's bipolar coagulation. The skin from which the hairs were removed was then cut out with a circular punch 0.5 cm. in diameter. These were studied for comparative destructive processes and the following was reported: On the section from which the hair was removed by negative galvanism, serial sections, stained with hematoxylin and eosin, are covered by stratified squamous epithelium of approximately normal thickness. Surrounding the point of entrance of the needle, the epidermis shows lysis over an area measuring approximately 1 mm. The hair shaft shows complete dissolution by the current. Both the inner and outer hair sheath membranes show spindling of the cellular nuclei. There is slight edema and granular degeneration of the surrounding collagenous connective tissue fibers. The other appendages or vessels of the corium appear normal (figures 4 and 5).

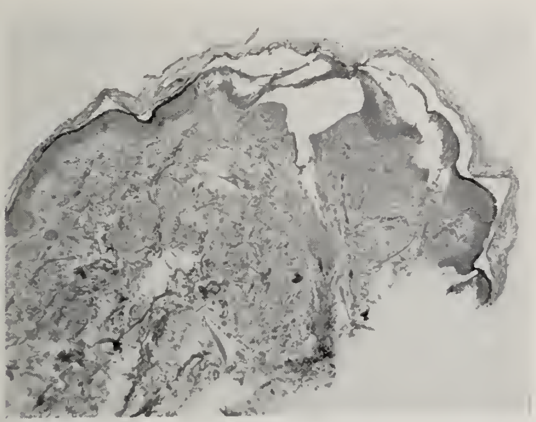

FIG. 4. Photomicrograph (× 55) of skin, showing destruction of hair follicle and surface epithelium. Hair removed by negative galvanic current.

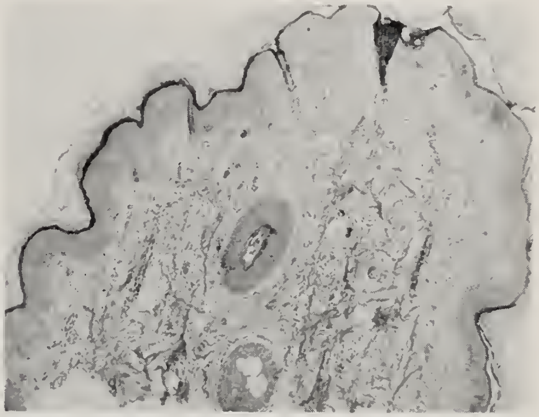

FIG. 6. Photomicrograph (× 75): Destruction of hair without destruction of the follicle. Hair removed by monopolar coagulation.

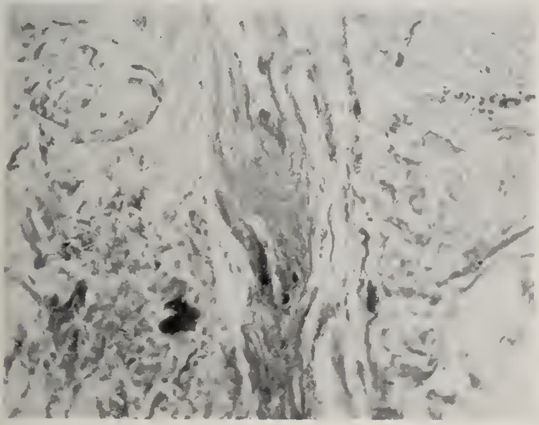

FIG. 5. Photomicrograph (× 185), showing destruction of hair follicle by negative galvanic current.

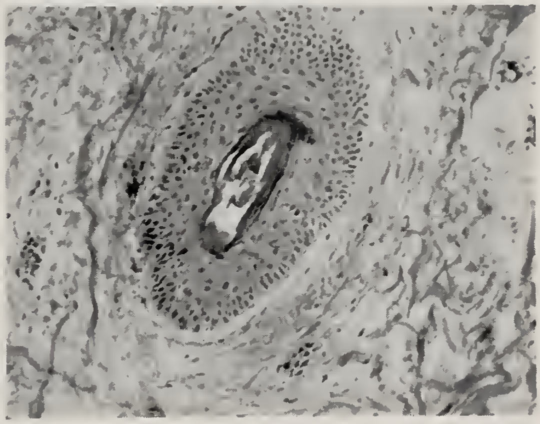

FIG. 7. Photomicrograph (× 235): Hair removed by monopolar coagulation.

The microscopic picture of the section of skin from which the hair was removed by monopolar coagulation shows the epidermis to be of normal thickness with no evidence of lysis or desiccation.

The hair shaft shows complete dissolution by the coagulation current, but the inner and outer hair sheath membranes are intact. The epithelium shows no spindling of the nuclei or other evidence of desiccation. The surrounding appendages and vessels of the corium appear normal (figures 6 and 7).

The section of the skin from which the hair was removed by bipolar coagulation shows the epidermis to be of normal thickness, but at the point of entrance of the desiccation needle there is a zone of lysis of the epidermis about 0.7 mm. in diameter. There is lysis of the hair shaft and both the internal and external sheath membranes, superficially. The surrounding skin appendages, vessels, and connective tissue of the corium appear essentially normal (figures 8 and 9).

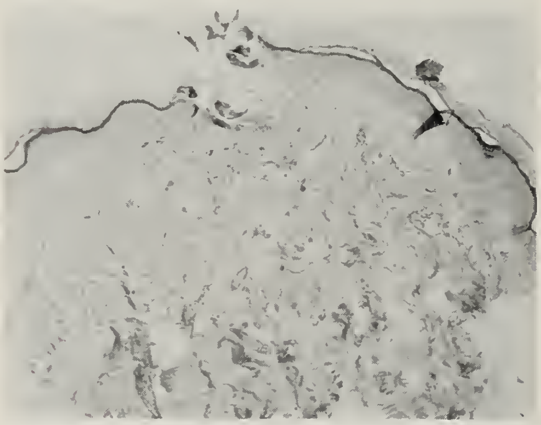

Fig. 8. Photomicrograph (× 60): Destruction of surface epithelium at point of entrance of needle electrode. Hair removed by bipolar diathermocoagulation.

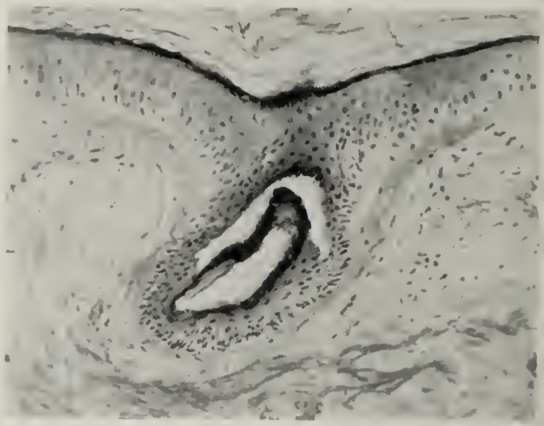

Fig. 9. Photomicrograph (× 235): Destruction of hair and partial destruction of follicle by bipolar diathermocoagulation current.

Comment

The greatest advantage of this method is that the papillae are destroyed almost immediately, whereas in negative electrolysis the destruction of the papilla is slow. The speed of destruction permits the removal of a greater number of hairs at one sitting, about 4 times as many as with negative galvanism. When the growth of hair covers a large area and is closely packed, this speed is of infinite value.

A comparison of pain in both methods is important. Because of the low amperage, the pain, with negative galvanism, is minimal, but it has to be applied for some time. With coagulation, although the pain would be great if applied for the same time as in electrolysis, the current is applied for fractions of a second, resulting in little or no pain. Any method by which tissue is destroyed will produce pain. Several patients who have had hair removed by both methods prefer the coagulation process.

When the removal of hair by coagulation has been performed carefully, irritation of the skin is practically nonexistent. In some cases there appears a faint erythematous blush in the area which has been treated. This is evanescent and lasts from 10 minutes to a half hour and produces no permanent changes. It is important, however, not to remove hairs which are too close to each other. The destructive process at the papilla which also destroys some of the epithelium and the blood vessels in that area would become a conglomerate area of destruction if the papillae treated at one time were too close together. It is a safe rule of the thumb that no area which has been treated should be treated again for 10 days to 2 weeks. In most cases this can be easily accomplished, since the hairs

(Continued on page 577)

THE DISTRICT OF COLUMBIA MEDICAL SOCIETY RAGWEED POLLEN COUNT

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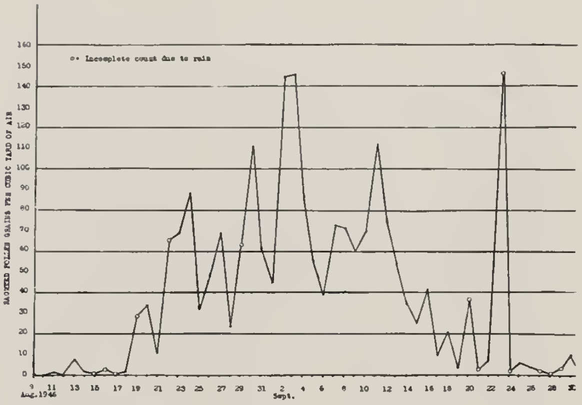
A STANDARD technic for measurement of pollen and mold concentrations was put into use in Washington for the first time in 1946. This technic has been adopted by the National Pollen Survey Committee of the American Academy of Allergy for use in their study of pollen concentrations throughout the country.[1] During the course of the year there are successive pollen concentration peaks, with trees, grasses, and ragweed appearing in that order. Ragweed, the chief cause of hay fever, begins pollinating about the middle of August, usually reaches a peak early in September, and is finished about October first. During the past ragweed season, daily counts of ragweed pollen concentration, measured by the new standard device, have been made available to the public through the press and radio, as a service of the Medical Society of the District of Columbia. The counts have also been available through the United States Weather Bureau. Clinical and experimental applications of the daily pollen count are discussed in this article. Chart 1 is a graph of this past season's daily ragweed pollen concentrations.

METHOD

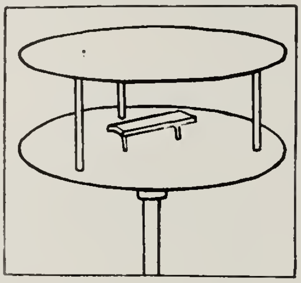
The measurement technic that has been adopted is the outcome of 15 years' experimentation, done chiefly by O. C. Durham, Technical Advisor of the National Pollen Survey Committee.[2,3] This technic makes use of a gravity pollen collection apparatus recently designed in accordance with modern aerodynamic principles.[4] The instrument used consists of 2 horizontal circular steel plates, 9 inches in diameter, held parallel 3 inches apart by 3 slender struts. A glass slide lightly coated with petrolatum is supported in a holder closely molded to the slide's dimensions, and held 1 inch above the lower plane. A 30-inch standard supports the above instrument, which in Washington is located on the roof of the downtown Weather Bureau building. Slides are exposed for 24 hours, and the number of pollen grains on a unit area of the slide are counted under a microscope. Calibration of this device against a volumetric air sampler has led to the determination that in 24 hours the number of grains of ragweed pollen deposited on 3.6 sq. cm. of the slide is equivalent to the average number of grains per cubic yard of air. While the volumetric method of pollen concentration determination is the most accurate of all methods, the processing required for each count is too time-consuming for it to be generally practicable in daily counting.

CHART I

Standard Ragweed Pollen Count for Washington, D. C. in 1946



The present instrument avoids several major errors inherent in the construction of previous slide shelters. By elevating the slide above the roof and above the floor of the instrument itself, "surface drift" of pollen grains to the sticky slide is avoided. The streamlined, parallel surfaces and the absence of obstructing sides minimize eddies of air which lead to erratic pollen deposit. The use of a flat rather than a curved roof to protect the slide from rain tends to circumvent ricochet of pollen grains from the roof to the slide.


Standard Air Sampling Device

Applications of the Standard Pollen Count

Clinical Response to Various Pollen Concentrations.—Ragweed-sensitive individuals vary considerably in their reaction to any given pollen concentration. Some persons sneeze when only 1 grain of pollen is present per cubic yard of air, and a few are resistant to as many as 60 or 70 grains in the same volume of air. In the average untreated case, however, counts above 20 spell trouble, and counts of a hundred or more are definitely high.

Evaluation of Effectiveness of Therapy.—In judging the effectiveness of a given treatment for hay fever or pollen asthma it is very important to know to how much pollen the patient is being exposed. That the patient is more comfortable this year than last has little significance if appreciably less pollen is in the air this year. An outstanding example of failure to take adequate cognizance of changes in pollen concentration occurred when vitamin C was introduced as a treatment for hay fever.[5] This therapy apparently was initiated with low doses at the onset of one ragweed season and the dose increased in successive weeks. The improvement credited to the larger doses of the drug presumably was a function of the change in pollen concentration. Of course the use of an adequate control group initially could have prevented the error of crediting the improvement to the vitamin, but careful observance of the fluctuation in pollen concentration also would have served as a check on the validity of the conclusions. Knowledge of the course of the pollen concentration can be an invaluable aid to the practicing physician whenever he must evaluate any hay fever medication without the benefit of controlled experimental conditions.

In consideration of the action of new drugs on allergies, the degree of antigenic stimulation must be taken into account. A given drug, ephedrine, for example, may be effective under conditions of relatively little antigenic stimulation and yet fail to give relief in a real crisis. The fact that there is considerable variation in pollen concentrations both from year to year and from city to city, may be a source of difficulty in the evaluation of new drugs. Thus the testing of a new remedy in a city where the pollen concentration is particularly high may not confirm favorable results reported in another city. Likewise, misleading results may be obtained during years when the pollen output is less than average. Although comparative counts are not available for previous years in Washington, reports from the northeastern section of the United States indicate that the ragweed concentration during this past season was relatively low.[6]

Diagnosis of Contributory Factors.—The typical ragweed-sensitive patient will show exacerbation in his symptoms at the time of exposure to a high concentration of the pollen, although sometimes this is not manifest until 12 to 24 hours after. Following the course of a patient and that of the counts will enable the physician to determine whether the response is typical or not. When an atypical course is pursued, the reason must be sought. Often it will be found that the afflicted individual is unsuspectingly exposing himself to a greater amount of pollen than is indicated by the pollen count. He may have gone driving, walked through areas containing ragweed plants, or sat under a fan. On the other hand, the difficulty may have been occasioned by nonspecific irritants, such as moth or fly killers, fresh paint, pungent fresh flowers, or surface changes in body temperature. If these more obvious factors can be excluded as possibilities, attention should be directed to specific allergens other than the ragweed. It is not uncommon for a person to be able to tolerate a given food or inhalent allergen (such as melons or corn, feathers or orris root face powder) throughout the year except when he is already upset by ragweed or other pollen. Comparison of the symptoms with the count is frequently the "tip-off" to look for these contributory offenders. The diagnosis is well worth the making, for in almost every instance the offenders can be eliminated or controlled.

Inter-city Comparisons.—Not infrequently information on relative ragweed concentrations is desired in connection with selecting vacation spots, moving to another city, or making business trips in the fall. Certain areas, such as the Pacific Coast or parts of the Adirondacks, are well known to be free or virtually free of ragweed pollen. However, our present knowledge concerning relative ragweed concentrations even between states, let alone cities, is very limited, and is one of the primary pieces of information to be gained from the study by the National Pollen Survey Committee. In the course of the next few years we will be able to tell a Washingtonian whether he can expect to be appreciably better off or worse should circumstances lead him to another major city in the fall.

This year in Washington a new chemical weed-killer, known as 2-4-D, is being tried experimentally on ragweed. Spraying was started very late in 1946 and no appreciable coverage was made. However, it is anticipated that the ragweed counts both in this and in other cities will be an all-important part of the evaluation of this and other measures designed to minimize the local pollen concentration. The relative importance of pollen carried from a distance in determining the local concentration is almost completely unknown. Pollen may be carried for great distances. In fact, pollen known to have come from Alaska has been deposited in Washington and Oregon.[7] The usual distance ragweed pollen is transported has been variously estimated as from 30 to 60 miles "or more."

SUMMARY

1. The Medical Society of the District of Columbia in 1946 sponsored daily ragweed pollen counts using the new standard technic adopted by the American Academy of Allergy for its national survey of pollen concentrations.

2. Daily pollen counts are useful as a control in judging the effectiveness of therapy for hay fever.

3. The daily pollen counts are an aid in the diagnosis of factors other than pollen concentration which are contributory to allergic symptoms.

4. The availability of standard pollen counts in different localities in the Nation will provide a travel guide for ragweed-sensitive persons, and will assist in establishing the effectiveness of weed-control measures.

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A CLINICAL EVALUATION OF LIVER DISEASE WITH SPECIAL REFERENCE TO PORTAL CIRRHOSIS

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The multiplicity of known functions of the liver and a probable host of unknown functions provide us with a background of disturbed physiology that lends itself to many pitfalls in the diagnosis of hepatic disease. Certain peculiarities of liver pathology are of special interest and are of fundamental aid in the approach to the problem of diagnosis. The liver is peculiarly immune to the ordinary types of inflammation seen in other parts of the body. Tuberculosis, syphilis and primary carcinoma are infrequent, whereas necrosis, fibrous replacement and liver-cell regeneration are common. It is with these latter processes that we are concerned in portal cirrhosis. By portal cirrhosis is implied a destructive process of the liver cells, atrophy, fatty degeneration and necrosis of the individual cells, with proliferation of new connective tissue and regeneration of parenchyma cells resulting in parenchymal and vascular changes leading ultimately to portal hypertension.

Primary liver cord tissues (including the epithelial lining of the bile ducts and gall bladder), as described by Arey, originate as a ventral sacculation of the foregut, the future duodenum, seen first in embryos of 2.5 mm. This diverticulum pushes directly into the splanchnic mesoderm and by splitting the mesentery, becomes encapsulated. Smooth muscle, connective tissue and the blood vessels of the liver, biliary passages and gall bladder are supplied by the mesoderm. Venous plexuses from the vitelline mesentery form the sinusoidal vessels. This intimate and early relationship of the liver-cell cords to the blood vascular apparatus is the primary histologic background for the metabolic functions of the liver in which it receives substances from the blood, stores or transforms them within the cells, and subsequently discharges them back into the blood stream.

Functions of the Liver

The principal known functions of the liver are as follows:

1. *External Secretions of the Liver.*—The formation and secretion of bile of a clear yellow or orange color is a continuous process within the liver cells. From 500 to 1000 c.c. of bile is formed in 24 hours and passes into the gall bladder where it is concentrated. Bile serves as a means of removing pigments and certain additional waste products. Its chief function in the intestinal tract is concerned with absorption of fats. Adequate absorption of vitamins D, E, and K and of carotene requires the presence of bile. Bile is necessary for adequate emulsification of fats in preparation for digestion by pancreatic and intestinal juice lipase. Bile also acts as a mild cholagogue and helps to neutralize gastric hydrochloric acid.

The principal ingredients of bile are the bile pigments, bile salts and acids, and cholesterol. Fatty acids, phospholipins, inorganic salts and mucin are among other constituents. Bilirubin and biliverdin (the green oxidation product of bilirubin) are end-products of pigment metabolism derived from the breaking up of the hemoglobin of red blood cells in the blood stream, and converted into bilirubin by the reticulo-endothelium system. Bacterial action in the intestine reduces bilirubin to urobilinogen, which colors the stool. Most of the urobilinogen passes out in the stools, but a small amount is re-absorbed into the portal circulation and almost entirely re-excreted by the liver. Under normal conditions only traces of urobilin are eliminated from the general circulation by the kidneys. Cholic acid is the most common bile acid formed in the liver and appears chiefly in combination with taurine and glycine as the bile salts, sodium glycocholate and sodium taurocholate. Bile salts unite with the fatty acids that result from the digestion of fats, and the formation of complex compounds of soaps, fatty acids and bile salts results in the absorption of most of the ingested fat.

2. *Carbohydrate Metabolism.*—Experimental hepatectomy is followed by hypoglycemia that is fatal within a few hours. The liver maintains the blood-sugar level by removing sugar from the blood, storing it as glycogen and releasing it as required. Muscle glycogen is not directly available for general use, but the lactic acid produced by muscular activity is converted into glycogen and stored by the liver. This production, storage and utilization of glucose is influenced by a number of hormonal and nervous factors. The pancreatic, pituitary, adrenal and thyroid hormones exert varying influences.

3. *Protein Metabolism.*—Protein metabolism is primarily that of amino acids containing the base, NH_2, and the acid, COOH, groups. The amino acids enter the portal vein by diffusion, and those not needed are broken up by the liver. This is accomplished by splitting the combustible amino groups (NH_2) with the formation of ammonia which combined with CO_2 forms urea and is excreted by the urine. This process is known as deamination. Certain amino acids are converted by the liver into glucose which may then be burned or stored as glycogen. The formation and destruction of uric acid may be an essential liver function.

4. *Fat Metabolism.*—The importance of bile salts in the absorption of fats has been mentioned. The fate of fatty acids is, as yet, not complete. Ketone bodies are formed principally, if not entirely, in the liver. Desaturation of saturated fatty acids is thought to be a major function of the liver. It is thought that the liver is concerned with the metabolism of cholesterol and it may possibly be formed by the liver. Pregnancy, nephrosis and severe liver damage all increase the blood cholesterol. Vitamins A, D and K, and probably E, are stored in the liver.

5. *Iron and Copper Storage.*—The Kupffer and hepatic cells form the chief storehouse of iron derived from food. Copper is likewise stored chiefly in the liver.

6. *Relation to the Composition and Volume of the Blood.*—Gastric tissue contains the material necessary for the production of an anti-pernicious-anemia factor, and this factor is known to be stored in the liver. Plasma protein may have its source in the liver, and the albumin and globulin fractions are probably produced there. Fibrinogen is formed within the liver. Reduction in blood prothrombin occurs when severe liver damage results in interference with the storage and utilization of vitamin K. Heparin is present in the liver, muscles and lungs. The regulation of blood volume, or the control of the balance between tissue fluids and fluids in the vessels is another important hepatic function.

7. *Detoxication.*—By means of chemical detoxication, by storage in liver cells, by excretion in the bile and by reticulo-endothelial activity, the liver renders many poisons harmless. For example, the fact that benzoic acid, when combined with glycine, yields hippuric acid, is the basis for the hippuric acid test of liver function.

8. *Relation to Glands of Internal Secretion.*—These have been mentioned under the discussions on fat and carbohydrate metabolism.

9. *Relation to Vitamins.*—Carotene is converted into vitamin A in the liver. Bile salts are necessary for carotene but not for vitamin A absorption. There appears to be a fault in carbohydrate metabolism in vitamin B_1 deficiency, and the B complex appears to be stored primarily in the liver. Vitamin D is evidently stored in the liver. Vitamin K and its relationship to prothrombin has been discussed.

10. *Heat Production.*—Body heat has as its main sources the liver and the muscles. This might well be supposed in view of the extensive chemical reactions occurring in these tissues.

THE TESTS OF LIVER FUNCTION

The complexity of liver functions, the capacity of the liver for regeneration, and the factor of safety, as evidenced by the necessity for the removal of more than 80 per cent of the liver in dogs before signs of impairment of function occur, all indicate the difficulties encountered in seeking accurate measurements of the efficiency of liver activity. None of the functional tests developed is infallible or applicable to all cases, nor do such tests take the place of clinical observations and the resultant impressions gained thereby. Results are often hard to interpret and often misleading.

The following interpretation of the various available laboratory procedures is presented with the details of technic omitted as being irrelevant in a discussion of this kind.

1. *Icterus Index.*—This is a crude estimate of the amount of bilirubin in the blood. The normal index is 3 to 6. The zone of latent jaundice is 6 to 15, and that of manifest jaundice is above 15.

2. *Van den Bergh Reaction.*—The direct reaction is a qualitative test believed to measure only "free" bilirubin. The presence of "free" bilirubin indicates liver damage and rupture of the bile capillaries. In obstructive jaundice there is a prompt or immediate direct reaction, whereas in jaundice due to liver damage there is a delayed or diphasic reaction. There is no reaction in uncomplicated hemolytic icterus.

The indirect reaction is the basis for the quantitative determination of bilirubin in all types of sera. Normal serum contains 0.1 to 2 mg. per cent of bilirubin. If obstructive jaundice and excessive destruction is ruled out, then the quantitative measurement of hyperbilirubinemia serves as a test of liver function. Liver cell function is considered to be impaired if there is a level of more than 4 mg. of bilirubin per 100 c.c. of blood. In hemolytic icterus only this indirect reaction is observed, the serum bilirubin averaging 6 to 7 mg. per cent. This quantitative indirect reaction is of value in detecting latent jaundice and in measuring the progress of manifest jaundice.

3. *Tests for Urobilinogen and Urobilin.*—Normal urine may contain from 0 to 4 mg. of urobilinogen, while the feces contain 100 to 250 mg. Moderate increase in urine urobilinogen and no increase in feces is found in obstructive jaundice with incomplete block of the common duct. With complete obstruction, neither stools nor urine contain urobilinogen. There is a tremendous increase in the feces in uncomplicated hemolytic icterus with a practically normal urine urobilinogen. If there is an associated hepatitis, both stools and urine show a marked increase. Urine, but not stool, urobilinogen is increased in cirrhosis.

4. *Bilirubin Tolerance Test.*—One mg. of bilirubin per kilogram of body weight is injected intravenously, and the blood level is measured at 5 minutes and 4 hours afterward. Normally all, or nearly all, of the bilirubin is excreted in 4 hours. The test is delicate but costly and therefore infrequently used. It is of value only in the absence of jaundice.

5. *Bromsulfalein and Rose Bengal Dye Retention Tests.*—These tests depend upon the excretory function of the liver, and cannot be reliably interpreted in the presence of a moderate or marked degree of jaundice. Bromsulfalein in the amount of 5 mg. per kg. of body weight is injected intravenously. Normally all of the dye is excreted in 1 hour. Ten c.c. of a 1 per cent solution of rose-bengal is injected intravenously and the disappearance of 50 per cent or more of the dye from the blood in exactly 8 minutes is considered normal. The results are comparable but not superior to the simple bromsulfalein test.

6. *Measurements of the Tendency to Bleed.*—Simple tests of bleeding and blood coagulation time are of value in view of the tendency toward

bleeding where there is liver damage. Vitamin K deficiency is associated with a tendency to bleed. Clinically, vitamin K deficiency is usually due to inadequate absorption produced by a lack of bile salts in the duodenum. Vitamin K deficiency produces hypoprothrombonemia. Severe hypoprothrombonemia is not always associated with hemorrhage, but it does seem to prolong the hemorrhage caused by other factors, especially trauma. Where there is liver damage, the liver is incapable of utilizing the available vitamin K, and hemorrhage is apt to occur, especially after trauma, as in surgery. These facts explain the likelihood of hemorrhage in operative procedures in the presence of severe jaundice, and especially so after operations in cases of obstructive jaundice. They also explain the lack of response to vitamin K and bile salts administration in the presence of severe liver damage. The measurement of blood prothrombin along with the simple tests for blood coagulation and bleeding time are usually adequate to detect bleeding tendencies and are essential in evaluating surgical risk in operative procedures of the bile passages.

7. The reduction of serum proteins and the reversal of the albumin-globulin ratio may be marked in portal cirrhosis with ascites.

8. Complete blood counts usually reveal a macrocytic anemia in cirrhosis.

9. *Glucose Tolerance Test.*—This is seldom of value in liver disease.

10. *Galactose Tolerance Test.*—This test is of practical clinical value in cases of jaundice. It is of aid in differentiating between intrahepatic and uncomplicated obstructive jaundice. There is a large margin of error in jaundice of long standing, and it is usually negative in both biliary and portal cirrhosis. Total excretion in the urine of more than 3 grams of sugar over a 5-hour period after the ingestion of 40 grams of galactose constitutes a positive test. In acute or subacute conditions with jaundice, a positive test suggests primary and diffuse liver cell damage.

11. *Blood Urea Determinations.*—This has no significant value in defining the type or degree of liver damage.

12. *Blood Cholesterol and Cholesterol Esters.*—These values are often difficult to evaluate. In portal cirrhosis the value is usually normal unless acute liver damage occurs.

13. *Hippuric Acid Excretion.*—This simple and reliable test is based on the ability of the normal liver to convert benzoic acid into hippuric acid by conjugation with amino-acetic acid. Normally, at least 3 grams of hippuric acid calculated as benzoic acid are excreted in the urine in 4 hours after the ingestion of 6 grams of benzoic acid. Excretion of less than 2 grams is commensurate with liver damage if gastric retention and renal disease have been ruled out.

14. *Serum Phosphates.*—The normal value for adults may reach 6. It is usually elevated in obstructive jaundice and in extensive malignant disease of the liver. Its clinical value is not yet certain.

15. *Cephalin-Flocculation Test.*—A colloidal suspension of cephalin and cholesterol in a patient's serum normally gives no flocculation or lipid precipitation in 24 to 48 hours. A strongly positive reaction occurs in acute hepatitis and a negative one in obstructive jaundice. Interpretation is sometimes difficult because hepatocellular injury may accompany obstructive jaundice.

16. *Takata-Ara Test.*—Of questionable value, this colloidal reaction performed on blood serum apparently gives confirmatory evidence of the presence of cirrhosis of the liver.

17. *Duodenal Drainage.*—Examination of the duodenal content is of value when doubt exists as to the presence of bile in the duodenum.

18. *Congo Red Test.*—Retention of 60 per cent of the dye in the blood after 1 hour suggests amyloid disease of the liver, and retention of 90 per cent is considered diagnostic.

19. *Examination of Ascitic Fluid.* In cirrhosis of the liver the ascitic fluid is a transudate with a specific gravity lower than that found in peritoneal carcinomatosis.

20. *Cholecystography.*—Visualization by X-rays of a normally functioning gall bladder is not only reassuring as to that organ but also connotes a reasonably efficient liver function.

21. *Fragility Tests of Red Blood Cells.*—Increased fragility of the red blood cells in hemolytic jaundice makes this test of value in differentiating it from obstructive jaundice.

22. *Wassermann Test.*—This should be a routine procedure in view of the fact that syphilis may produce the clinical picture of catarrhal jaundice, tumor of the liver and cirrhosis.

PORTAL CIRRHOSIS

With these concepts of liver physiology in mind, I would like briefly to consider the problem of portal cirrhosis, the commonest of the several types of cirrhosis.

Etiology.—The exact cause and the pathogenesis are not known. The disease is most common in males in late middle life. Alcohol has long been considered the greatest potential factor. Extensive studies by numerous investigators in recent years make it plausible that the disease is primarily a deficiency disease, and its frequent occurrence in alcoholics is explained by the known poor dietary habits of the alcoholic. This is substantiated by the knowledge that cirrhosis of the liver is endemic in regions where nutritional deficiencies are widespread and common. Chaikin and Schwimmer[1] have reported 246 cases among whom there was a definite history of alcoholism in 104. Ratnoff and Patek[2] have reported an incidence of 54 per cent of alcoholics in their series of cases. Of Chaikin's and Schwimmer's 246 cases, 33 of the 104 alcoholics admitted poor nutrition, 43 claimed a good diet, and in 49 no clinical data were available as to diet. Seventeen of their cases gave a definite history of malnutrition, and in 34 cases, in which exact clinical data were available, there was a history of neither alcoholism nor malnutrition.

Failure of our results in treatment are most often due to the failure to look for and recognize latent cirrhosis which may be symptomless. To illustrate the incidence of latent cirrhosis, I would like to point out that Ratnoff and Patek[2] found cirrhosis as an incidental finding in 49 of a series of 435 autopsies. A 52 per cent latency among 160 cases with necropsies was reported by Rolleston and McNee.[3] Thirty-five per cent latent cirrhotic livers were reported by McCartney[4] in 245 autopsied cases.

The protean manifestations of the disease make early diagnosis difficult. It is thought (McCartney) that a cirrhotic process can be arrested, particularly when parenchymal involvement is minimal and decompensation has not taken place.

Symptomatology.—The preascitic stage is apparently much more prolonged than the clinical signs indicate. It is unfortunate that the disease is seldom recognized at this time. Perhaps the earliest symptoms are gastrointestinal, and a history of nausea, anorexia and occasional vomiting, especially in the morning, can usually be obtained. Such a history in a chronic alcoholic should suggest an early cirrhosis, and liver function studies should be made. Hematemesis frequently is the first symptom. The sclerae are often muddy. In the series reviewed by Ratnoff and Patek insidious swelling of the abdomen was the most common first symptom, and occurred in 25 per cent of their cases. Painful hemorrhoids may usher in the symptoms. In 12 per cent of their cases abdominal pain generalized or localized to the epigastrium or right upper quadrant was the earliest manifestation of the disease. Among other specific primary complaints are jaundice, edema of the lower extremities, weakness and abdominal distress. As the disease progresses there is weight loss which is apparent on examination but which may not be apparent to the patient because of the weight of the accumulated ascitic fluid and tissue edema.

With progression of the disease, hemorrhagic phenomena such as epistaxis, purpura, hematemesis, melena, bleeding gums, petechiae, menorrhagia and metrorrhagia may occur.

In addition to anorexia, nausea and vomiting, the gastrointestinal symptoms frequently include flatulence, excessive eructations, constipation or diarrhea. None of these are specific symptoms.

Upward pressure of ascitic fluid often produces dyspnea. Frequently there is low-grade persistent cough. These patients are susceptible to respiratory infections and often run a low-grade fever.

Urinary symptoms, if present, vary from frequency of urination and nocturia to oliguria (especially in the presence of ascites).

The pitiful picture of the terminal stages of portal cirrhosis is one of an apathetic, dull, emaciated, bedridden patient with muddy sclerae and a muddy pallor of the skin. There are edema and marked abdominal enlargement, cyanosis, hyperpnea, half-dried blood in the nostrils and mouth, and pulsating telangiectases on the face and chest.

The physical signs most frequently encountered in the order of frequency are as follows: ascites, palpable liver, jaundice, edema, palpable spleen, hemorrhoids, fever without apparent cause, dilated veins, telangiectases, spider angiomata, signs of peripheral neuritis, varicose veins, hyporeflexia, absent deep reflexes, hydrothorax, scanty body hair, pigmentation over the shins, and clubbed fingers or curved finger nails.

This detailed review of symptomatology and physical signs is included as an added incentive to early recognition of the disease.

Treatment.—Both clinical and experimental observations have led to the changing concepts in the treatment of portal cirrhosis.

The clinical observations are:

1. The high incidence of cirrhosis in areas where nutritional diseases are endemic.

2. Coincidence of enteric diseases with deficiency states and cirrhosis, and,

3. The incidence and association of alcoholism with deficiency states and alcoholism with cirrhosis.

The experimental observations are:

1. The vulnerability of the liver to injury by hepatotoxins in the presence of starvation.

2. The lack of certain food factors in yeast causing fatty changes in the liver with impairment in its function.

3. The production of cirrhosis in rats and rabbits in yeast-deficient diets.

4. Protection of the liver from hepatotoxins by a high protein diet, and/or feedings of yeast.

The conclusion is that there is a significant relationship between the development of cirrhosis and nutritional deficiencies.

With these new concepts and observations in mind, the following approach to the problem of treatment must be meticulously engineered so that there is a minimum of discouragement and monotony, and a minimum of expense for a régime that may not show results for 2 to 10 months. The therapeutic objectives are simply to find and eradicate the cause and to facilitate repair and regeneration to a satisfactory state of function by keeping the glucose, protein and fat content of the liver within normal limits. A high-protein, high-carbohydrate, low-fat, high-caloric, high-vitamin diet, supplemented by the oral administration of Brewer's yeast, iron and liver concentrates, and vitamin C and cod liver oil concentrates, is employed. The proteins of vegetable and dairy products are thought to be the most readily used, and especially those rich in cystine and methionine. The carbohydrates most readily assimilated are such as jellies, marmalades, honey, fruit juices with sugar, and 15 to 20 per cent vegetables. Alcohol is indicted in any and every form, and spices and highly seasoned food are avoided. Parenterally, crude liver extract and the vitamin B complex have been administered.

Choline (as soy bean lecithin) or choline chloride is said to decrease the incidence and severity of fatty livers (Brown and Muether). I have not had personal experience with its use.

The institution of such a régime in early cirrhosis markedly improves the prognosis. Once decompensation has occurred, the prognosis is grave.

(*Continued on page 577*)

THE CONTRACEPTIVE DIAPHRAGM: IMPROVED TECHNIC

AARON H. GERBER, M.D.

Washington

THE contraceptive failures of the diaphragm and jelly or cream method have been variously estimated. Failures ranging from 5 per cent to over 15 per cent are reported.[1] Such failures may in some cases jeopardize the health and life of patients. It was thought justifiable, therefore, to present a new, simple method designed to minimize one of the causes of contraceptive failures, inadequate instruction of the patient.

The objective sought in placing a diaphragm, according to Dickinson, is to divide the vagina into an "upper anterior pocket holding the cervix and lower or posterior part providing the channel for the penis. She must learn to recognize the cervix both covered and defectively protected." No one can properly disagree with the above statement. Clinical experience, however, supports the conviction that many patients leave the examining table with only a vague notion as to what and where the cervix really is. The more conscientious of these patients discard the diaphragm and resort to less efficacious methods;[1,2] others insert the diaphragm "blindly." In the latter group it is only the anatomic contour of the vagina, aided by the contraceptive virtues of the cream or douche, and abetted by the factor of chance that prevent pregnancy. The role of unsuspected infertility is insufficiently credited.

It is these two groups of patients, the fearful and the blissfully ignorant, that contribute to the majority of failures in the use of a diaphragm.

To offset these objections the following method is described in detail:

1. History and gynecologic examination.
2. The patient is shown a diagrammatic chart depicting the pelvic organs. The mechanism of the diaphragm is explained. The importance of identifying the cervix is stressed.
3. The anterior cervical lip is gently grasped with a Vulsellum forceps (the discomfort is very slight and the bleeding is insignificant).
4. The cervix is gently pulled down to the introitus—within easy reach of the patient.
5. The patient is instructed to follow the instrument until the cervix is reached.
6. When the patient is certain of her identification of the cervix she is instructed to follow the cervix with her finger as the examiner replaces the cervix upward and backwards.
7. The Vulsellum is removed and the patient is once more requested to palpate the cervix.
8. A fitting ring of suitable size is selected and placed, and the patient is asked to examine the relationship of the ring to the cervix and symphysis.
9. The procedure is repeated employing a diaphragm.
10. The patient is asked to place and remove the diaphragm a number of times until both she and the examiner are certain that confidence based upon correct usage has been attained. The "check-up" visit is eliminated. Certainly, procedures requiring three separate visits are found unnecessary.[3]

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President's Page

A WORD OF THANKS

I have had so many compliments concerning the 17th ANNUAL SCIENTIFIC ASSEMBLY directed toward me personally that I wish to disclaim all credit and responsibility, except that of being there. Members of the various committees and the faithful office force of the Society were responsible for what has been, by all odds, the most successful ASSEMBLY to date.

The sparkplug of all the arrangements was Ted Wiprud. Coöperating with him were the following: Dr. W. Ross Morris, General Chairman, and Dr. Robert H. Groh, Vice Chairman of the Committee on Arrangements, both of whom did more than any of us realize in planning the ASSEMBLY; Dr. Robert J. Coffey, Chairman of the Subcommittee on the Scientific Program; Dr. Arnold McNitt, Chairman of the Subcommittee on Public Meeting; Dr. Herbert P. Ramsey, Chairman of the Subcommittee on Social Affairs; Dr. Emil J. C. Hildenbrand, Chairman of the Subcommittee on Scientific Exhibits; Dr. J. Lawn Thompson, Chairman of the Subcommittee on War Souvenirs Exhibit; Dr. A. Frank Kreglow, Chairman of the Subcommittee on Motion Pictures; Dr. Helen G. Kain, Chairman of the Subcommittee on Women Physicians; Dr. Harold M. Hobart, Chairman of the Subcommittee on Finance; and Dr. Luther Snyder, Chairman of the Subcommittee on Attendance. All of them performed yeoman service for which the Society is deeply grateful. The office force, who worked for months arranging the various details of the program, deserve our unqualified appreciation.

We shall look forward to an equally good ASSEMBLY this coming year—a meeting so inspiring and satisfactory from the scientific and social point of view that the privilege of attending and participating in the event will prove to be one of the most satisfying features of membership in The Medical Society of the District of Columbia.

William P. Herbst Jr

Editorials

A PUBLISHER READS HIS MAIL*

Shortly after I received an invitation to write a guest editorial for MEDICAL ANNALS, two very interesting reports arrived in one morning's mail. These reports in their way highlight the wide range of current opinion on the proper relationships that should exist between the doctor, the people, and the Government. The first, forwarded with a sponsoring letter from Mrs. Eleanor Roosevelt, was an article written by Ernest Boas, M.D., of the Committee for the Nation's Health, and entitled "Why Do We Need National Health Insurance?" The second was the regular bi-monthly bulletin of the Blue Cross Commission of the American Hospital Association. I believe that my message can best be told by putting some of the material from these two reports into juxtaposition.

Dr. Boas sets out to prove that only by a system of governmentally controlled and administered health insurance can the people of this country receive adequate and satisfactory medical care. In so doing, he makes short shrift of existing voluntary medical plans. To quote: ". . . voluntary plans fall far short of meeting the needs of the country . . . protection offered by voluntary sickness insurance in this country is minute in comparison to the need. A mere handful have complete medical coverage."

Dr. Boas goes on to dismiss lightly the charges that national health insurance will lead to regimentation and political control of medicine, that it will lower the standards of medical practice, and destroy the doctor-patient relationship.

It is in the field of preventive medicine that Dr. Boas finds full justification for state control of medicine. He asserts: "No one challenges the principle of the use of public funds for the prevention of disease . . . preventive medicine begins with measures of personal hygiene and health examinations instituted by the medical practitioner. So it is a logical and natural step to turn to government for funds to extend adequate medical care to all citizens of this country."

* * * * *

Turning to the September-October bulletin of the Blue Cross Commission, it is not necessary to underscore the important points of this report; they are self-evident. Dr. Boas, in using the phrase "voluntary plans fall far short of meeting the needs of the country," has picked up the well-worn and familiar slogan originally introduced seven years ago when Senator Wagner brought forth the first proposed bill for Federal health insurance. At that time such a statement made sense and could not be refuted either by history or statistics. But does this statement hold true today? I quote from the Blue Cross bulletin: "In 1937, barely a million persons were prepaying their bills for future hospital care through a handful of non-profit plans. Today, Blue Cross has more members than any other organization in the United States, more than the combined populations of Norway, Sweden, Denmark, Holland and Belgium." The chart graphically illustrating this phenomenal growth indicates a present-day membership of 24 millions of people.

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* This is the ninth in a series of guest editorials by distinguished physicians and laymen. Others to follow will deal with the scientific, social and economic aspects of medicine.

The report continues: "Enrollment in 39 medical-surgical plans reached a total membership of 3,026,446 on July 1, after a second quarter growth of 384,398 members, the largest in their history. Total medical-surgical plan membership in 35 areas was 22.7 per cent of Blue Cross membership there on July 1. During the first six months of 1946 these plans grew at a rate 43.9 per cent as fast as Blue Cross."

To a layman who is highly interested in improving the general standards of health throughout the United States and the world, the above figures on the tremendous growth of enrollment in both prepaid hospitalization and medical-surgical plans are the most convincing possible answer to the theory which Dr. Boas puts forward. An increase of more than 23 million persons in the past nine years is a record of which any organization could well be proud. This record proves that within the framework of our present social and economic system in the United States, we have workable methods by which the individual citizen can receive all the medical benefits which are promised to him through plans for complete socialization of the profession. There is also, however, a warning note– that if the enrollment in both prepaid hospitalization and medical-surgical plans does not continue to grow, tremendous pressures will be brought to bear upon the political representatives of the people to adopt far-reaching and extreme plans for complete socialization such as the one which Dr. Boas and his group espouse.

Roy E. Larsen
President, Time Incorporated

POSTGRADUATE EDUCATION FOR THE PRACTICING PHYSICIAN

It is a truism which has been repeated by generations of commencement-day orators that education does not end upon graduation from school but continues throughout life. Nowhere is this fact more pertinent than in the practice of medicine. New facts—new knowledge of the body and its behavior, additional technics of diagnosis, new methods of treatment—come hurling at us so fast that we often feel forced to heap them all in a single pile and let it go at that. But, just as surely as we do, we find that the pile contains so many heterogeneous elements that we can never find anything when we need it. It is imperative that these facts be sorted out and placed in separate piles, if not when they come to us for the first time, then, certainly, at periodic intervals. Fortunate is the physician whose leisure is sufficient and whose time is properly systematized so that he can do the former. Most of us must rely upon the latter system. Here lies the value of postgraduate training to the practicing physician.

One type of postgraduate course is known as the "refresher course." If such a period of study is to be of real benefit to the doctors who attend it, it should go beyond its name and sort out all the facts, new and old, which have a bearing upon the particular subject which is to be covered. Such courses usually last from a week to a month. As they are arranged at present, however, they are attended by certain problems. One of these is that the physicians, in many instances, must leave their practices and travel some distance in order to attend them. Another problem stems from the fact that the physicians who register for the course vary in the amount and kind of training they have had in the past, as well as in native intelligence and in the zeal with which they pursue their studies. No single group of studies can be planned which will satisfy all these diverse needs. A third unfortunate feature of these courses is the isolation of the subject matter contained in them. Usually they do not tie in with other courses nor with many of the things that the doctors are doing in their practices.

We believe that refresher courses should continue, but that attempts should be made to improve them. Some suggestions which may help are: (1) series of courses at intervals of several months or a year apart which, while separate, will follow a central guiding plan; (2) perhaps better still, courses which take up one or two afternoons or evenings per week throughout the entire year and do not require that the doctor absent himself from his work; (3) speakers who would go to the cities or counties where the doctors live, rather than making the doctors come to them; (4) examinations at the end of each course and some system of giving credit for the courses successfully passed, and (5) more integration of the postgraduate work with the physician's own practice. The first three suggestions are self-explanatory. We are well aware that in making the fourth suggestion we are treading on dangerous ground, but we believe that every honest man will admit that he studies harder when he has a definite goal ahead and exerts more of an effort when he knows that the effort is expected. Although short courses are not credited toward the qualifications of specialty boards, there is no reason why the physician could not be given a certificate for a course attended and successfully passed. This would be testimony to his colleagues and his patients that he is alert, progressive and interested in his work. The last suggestion can be followed by having physicians participate more in their own postgraduate work. They should report upon and on occasion look up material and write case reports regarding certain interesting cases occurring in their own practices. The incorporation of these procedures into a postgraduate course is merely a matter of administration. The material is there, and the physicians and the teachers are willing. All that is needed is more interest on the part of the profession and more willingness on the part of medical schools and other agencies to bring the physicians, the patients, the teachers and the pertinent facts together.

Harry F. Dowling, M.D.

EYESIGHT AND OPERATION OF MOTOR VEHICLES

The Director of Vehicles and Traffic of the District of Columbia has been making an effort to rid the streets of Washington of reckless and incompetent driving. In his efforts to carry out such a program it was requested that the Medical Society of the District of Columbia appoint a Special Committee on Traffic composed of representatives of the various specialties in medicine. This committee met with the Director and made a careful study and evaluation of the physical standards which were deemed necessary to insure competent driving of motor vehicles from this standpoint.

One of the most important considerations was the establishing of visual standards for drivers.

In 1938 the American Association of Motor Vehicle Administrators appointed a committee to direct investigation and collect information that would be of value to Motor Vehicle departments. After extensive research and study this committee recommended a minimum standard examination for drivers of motor vehicles. There were found to be three states that had never passed a driver license law. It is understood that there is still one state which does not require a license to operate a motor vehicle.

It was found that only 33 states and the District of Columbia required all new drivers to take a vision test, and there was no uniformity in carrying this out. The visual acuity requirement varied from 20/30 to 20/70 (Snellen rating). There was no record of periodic visual testing nor of tests for defects in the field of vision in any of the states.

In June 1939 the American Medical Association adopted the following resolution governing the visual standards for drivers:

"Resolved that the following be accepted as the approved American Medical Association standards:

A. For an unlimited license.

1. Visual acuity with or without glasses of 20/40 sn. in one eye and 20/100 sn. in the other.

2. A form field of not less than 45 degrees in all meridians from the point of fixation.

3. The presence of binocular single vision.

4. The ability to distinguish red, green and yellow.

5. Night blindness not to be present.

6. Glasses, when required, be worn while driving and those employed in public transportation be provided with an extra pair.

* * * * *

C. Renewals, Retesting and Reëxaminations.

1. Renewals of license to be issued at least every third year. The applicant shall with each renewal make a declaration that he knows of no visual defect which has developed during the past year.

2. Retesting of acuity be made at least every six years.

3. If any visual defects have developed, an examination by an ophthalmologist and the report thereof to be required before reissuing the license.

4. License to state thereon the specific limitation for driving."

There are a number of conditions which affect vision at various age periods and which are progressive or become more manifest with increasing years.

Myopia is a condition which begins to develop, as a rule, in the teen-ages and tends to progress until some time in the twenties, at which time it becomes fairly stationary. An individual with even a mild degree of myopia does not possess normal visual acuity for distance. With moderate degrees of myopia distant visual acuity is very poor without the aid of corrective lenses. Another condition which usually becomes manifest in about this same age period is pigmentary degeneration of the retina. With this disease the individual may retain relatively normal visual acuity but at the same time develop extreme degrees of night blindness and contraction of the visual fields.

The majority of our population is hyperopic ("far-sighted"). A person with moderate or even a fairly high degree of hyperopia usually maintains good visual acuity until some time in the late thirties or early forties. At this time, with the normal failure of accommodation, the visual acuity for both distance and near begins to drop. This may take place rather rapidly and the individual becomes a traffic hazard without the aid of glasses.

There are a number of diseases of the eye and the central nervous system which are more prevalent beyond the age of thirty-five. These may render the individual decidedly unsafe on the public highway.

It is an established fact that the eyes of most people change with increasing years. Because of this change the visual acuity or visual fields may change to the point that the individual becomes a definite hazard as the operator of a motor vehicle on the public highway.

Therefore the ophthalmologist who was a member of the Special Committee on Traffic made the following recommendation:

That examination of the eyes be required every six (6) years for renewal of permit to operate a motor vehicle on the public highway. The eye examination should include a check of the field of vision as well as visual acuity.

The following reasons demonstrate the rationale of the procedure:

1. Eyes undergo change from birth until death. Therefore there may be marked changes in visual acuity over a period of years, during every decade of life.

2. There are several diseases of the eyes which produce marked contraction of the field of vision before there is a very great loss of central visual acuity.

3. Myopia may increase very rapidly in young people and result in marked reduction of central visual acuity without glasses.

J. N. G.

In and Out of Focus

BY THE OBSERVER

First Postwar Assembly a Success

All those who had a part in preparing for the 17th Annual Scientific Assembly will not soon forget the hectic days that preceded the meeting. Problems incident to the transfer of the Assembly from the Mayflower Hotel to the Hotel Statler were, to say the very least, trying. Not only were the rooms arranged quite differently, necessitating the construction of much new booth equipment, but personnel inadequacies at the Statler, through no fault of the management, left much to be desired.

Washington hotel workers were not in an especially happy mood immediately prior to the Assembly. As if difficulties involved in the transfer to the Statler were not enough, a strike was announced for the first day of the Assembly. It looked for a time as though hundreds of hours of labor and several thousand dollars invested in the meeting would be lost. However, as so often is the case, the worst did not happen, and the Assembly got off to a satisfactory, if somewhat uncertain, start. It was soon evident that it would be the most successful meeting to date. Attendance topped all records, as the following figures show: Physicians, 1,439; Medical Students, 240; Nurses, 104; Pharmacists, 22; Technicians, 38; Hospital Superintendents and Administrators, 9; Miscellaneous, 372; Total, 2,224.

If your Observer were asked what was the most impressive thing about this year's Assembly, he would unhesitatingly say it was the attendance at scientific meetings. At no previous meeting have physicians attended scientific sessions so faithfully. From morning until late afternoon, the large Presidential Ballroom was filled to near-capacity. On the last day, your Observer, who stayed at the Statler throughout the Assembly, stopped at the registration desk at 9:00 a.m., thinking there would be no one around, as the day's proceedings were not scheduled to begin until an hour later. To his surprise, there were a number of physicians waiting to register, and many others impatient for things to get going. This was most unusual. In former years, there was always concern about the scientific program on the morning of the last day, because of the weariness of participating physicians. There was no letdown this year, which made everyone connected with the Assembly very happy.

The Scientific Exhibit was certainly equal, if not superior, to any yet presented. At least, your Observer was so informed by a number of physicians in attendance. The War Souvenirs Exhibit, too, thanks to a very able chairman, was exceedingly well handled.

No feature of the Assembly is the source of more anxious moments than the public meeting. The threat of public indifference always hovers over the committee in charge. There has never been reason for special worry, because the crowds at this meeting have usually been large. This year was no exception. The talk given by Captain George M. Lyon, M.C., U.S.N.R., on "Atomic Energy and Your Future Health" was certainly timely.

On the final evening, the first Annual Dinner since the beginning of the war was held. It was well attended, some three hundred and fifty being present. The program was a little overlong, but no one minded particularly. Major General Alden H. Waitt, U.S.A., Chief of the Chemical Corps, United States Army, who spoke on "Can We Win the Peace Through Science," was undoubtedly one of the ablest and most effective speakers heard by the members of the Medical Society and their wives in many a day. In fact, his was one of the most significant addresses of the Assembly. Guests at the dinner included the Surgeons General of the Army and the Public Health Service and their wives, Major General and Mrs. Albert W. Kenner, Brigadier General and Mrs. Wallace H. Graham, Dr. Walter A. Bloedorn, Dean of George Washington University School of Medicine, and Father Paul A. McNally, Regent and Dean of Georgetown University School of Medicine.

Mention should also be made of the luncheons, beginning with the Society's luncheon on the first day, with about 400 members and their guests in attendance. On succeeding days luncheons were given by the George Washington University Medical Society and the Georgetown University Medical Alumni Association. All of them must be rated as very successful.

Being General Chairman of the Committee on Arrangements for the ASSEMBLY is a heavy responsibility. Dr. W. Ross Morris distinguished himself in handling this year's meeting, and to him certainly should go a great share of credit for its success. Without exception, chairmen of the subcommittees—Program, Dr. Robert J. Coffey; Finance, Dr. Harold M. Hobart; Attendance, Dr. Luther Snyder; Public Meeting, Dr. Arnold McNitt; Social Affairs, Dr. Herbert P. Ramsey; Women Physicians, Dr. Helen G. Kain; Scientific Exhibits, Dr. Emil J. C. Hildenbrand; War Souvenirs Exhibit, Dr. J. Lawn Thompson, Jr.; and Motion Pictures, Dr. A. Frank Kreglow—acquitted themselves most creditably.

As stated in the beginning, your Observer was particularly happy because so many physicians found the scientific sessions profitable. After all, the heart of the ASSEMBLY is the scientific program.

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The Happy Life of an Executive Secretary

It has often occurred to your Observer that his experiences as an executive secretary would prove interesting reading to doctors, and even to laymen. His many years of association with physicians has taught him a great deal, which might be enlightening to the medical profession. Perhaps he might also give the public a better insight into what doctors are really like. But all of this would necessitate some rather plain talk, in which executive secretaries do not often indulge. If they do, they do so at their peril.

Of course, your Observer could write about the duties of an executive secretary, but he doubts that he could do anywhere near as good a job as was done recently by Henry Clepper, of the Society of American Foresters. Mr. Clepper recently wrote an article entitled, "Running a Professional Society, or The Happy Life of an Executive Secretary," which appeared in the October issue of *The Scientific Monthly*. It was sent to your Observer by Dr. Paul F. Dickens, who was intrigued by the subject.

As is well known, there are hundreds of professional societies in this country. If one were to ask a professional man why he was a member of his organization, Mr. Clepper says he would probably "murmur vaguely something about keeping abreast of developments in his field."

> "Invariably, a description of a professional society in a directory or yearbook," he says, "is written in cold and unemotional prose. Its stated objectives usually are 'to advance scientific and educational development . . . to promote the technical practice . . . and to maintain high standards' of something or other, etc. Now these are necessary and desirable objectives in any endeavor, as every right-thinking person will agree. But in reading such a description, one would never suspect that the organization is composed of warm human beings who, for all their scientific training and specialized technical knowledge, enjoy drinking a cocktail, casting a fly rod, or relaxing with a 'whodunit.' "

Passing on to the subject of his article, Mr. Clepper writes:

> "I cannot think of any class of worker whose lives are more likely to be frittered away by detail than secretaries of professional societies—if they permit it. During a single day a secretary may be expected to display the sympathetic understanding of a father confessor, the diplomacy of an embassy attaché, the business acumen of a wholesale merchant, the salesmanship of a used-car dealer, the financial judgment of a stockbroker, and the

information of a radio quiz expert. In between times he dictates letters, signs checks, reads manuscripts, writes reports, talks to callers, keeps appointments, answers questions, gives advice, receives advice, laughs at funny and unfunny stories, shakes hands—and loves it. Often his really productive work may be done after office hours, usually at home."

As to the qualifications of an executive secretary, he says:

"I would rate as his foremost qualifications for success as secretary of a professional society Gibbon's dictum regarding politeness and good sense. But I would add two others, sincerity and enthusiasm. And a sense of humor helps. Oh, how it helps!

"Still another most important endowment for success—and happiness—as an executive secretary is a genuine liking for people. A story, doubtless apocryphal, is told of the late Clemenceau, Tiger of France. He is alleged to have said that he loved France but hated the French. If true, he would not have made a good executive secretary of a professional society. For a society is a body of persons, and an executive secretary must have the gregarious temperament that enjoys association with people.

"Not only must he like people, he should be one of those fortunate individuals of whom it is always said with admiration, 'Why, he can remember names as well as faces.' Perhaps required experience for an executive secretary should be at least one year of employment as a room clerk in a large hotel. One is not born with an aptitude for remembering names and faces. It is learned the hard way."

Mr. Clepper has something to say about members, too.

"I often wonder how many professional men and women who attend a meeting of their society realize the preparation that has gone into it. Even after a program committee and a committee on local arrangements have been appointed, it is usually the executive secretary's responsibility to see to it that registration, printed programs, meeting rooms, banquet rooms, badges, tickets, secretarial help, press service, and all the other minutiae essential to the smooth functioning of a big meeting have been arranged.

"A colleague, the executive secretary of an engineering society, once offered the suggestion that an essential qualification for his kind of job should be five years with Barnum and Bailey's circus. The analogy between a large professional meeting and a three-ring circus complete with side shows is not so far fetched as may appear."

Of course Mr. Clepper eventually gets to politics in professional organizations. There lie the pitfalls which the executive secretary must avoid. Mr. Clepper puts it this way:

"Here is where the executive secretary had better watch his step. If he fails to espouse the movement, he may be called a reactionary. If he goes all out for it, he may be dubbed radical. Even when he personally desires to do one or the other, he may do neither, not out of spinelessness, but simply in the interest of solidarity. Not to put too fine a point on it, the executive secretary is well advised to perform the function his title implies, that is, execute the policies of his officers and avoid championing causes and movements.

"To the extent that it is humanly possible, the executive secretary must be all things to all men."

He summarizes the "native endowments and acquired abilities" of an executive secretary as follows:

"1. Adequate technical training in his field.

2. Tact, mature judgment, sincerity, and enthusiasm.

3. The temperament gregarious, combined with love of his fellow-men.

4. A sense of humor.

5. A conviction of the value of his profession to human progress.

6. Ability to remember names and faces, especially in dues-paying members in good standing.

7. Ability to represent his profession competently and favorably before the public.

8. Adroitness in avoiding extraneous issues and determination to stick to the main job.

9. A readiness to submerge his personality for the good of the cause.

10. A belief and pride in the nobility of service."

From all this, it would appear that an executive secretary, if he measures up to the requirements of his job, must be quite a fellow.

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"They Have Been Drugged—"

For more years than he would like to admit, your Observer has endeavored to interest physicians in the economics of medicine. It has been uphill and sometimes discouraging work. There is still too much apathy; however, your Observer likes to believe that although a great deal remains to be done, the situation is much improved.

Dr. Paul R. Hawley, Medical Director of the Veterans Administration, must have shaken apathetic physicians considerably with his caustic comments on their indifference to economic problems involved in medical care. At the opening ceremonies of George Washington University School of Medicine on September 30, he let go with both barrels. His remarks were surprising, in view of what he had previously said to and about the medical profession. Your Observer recalls that at recent meetings of the House of Delegates of the American Medical Association, Dr. Hawley had been more than emphatic in his opposition to any form of government medicine. He had insisted private practice must in no way be jeopardized. Something evidently had happened to change Dr. Hawley's mind. For he said, after a rather lengthy discussion of the professional aspects of medical care, "Advances in medicine are not wholly blessings in so far as the patient is concerned. They have brought with them problems that have not been solved. The significant elevation of the standard of medical practice has greatly increased the cost of medical service. This is now a matter of grave public concern.

"What the ultimate solution of this problem of medical care for patients in low income brackets will be is not clear at the moment. But it is a fact that can no longer be denied nor evaded that medical care has become so expensive as to place it in the class of luxuries. This is a problem which will vitally affect your futures. The great majority of your predecessors have been curiously indifferent to this problem. *You* cannot afford to be indifferent to it. It is a problem that was apparent at least ten years ago; but just now, and I am afraid too belatedly, organized medicine is taking for the first time constructive steps toward its solution. I say 'belatedly' because I am afraid that other agencies, less qualified to attack this problem, have taken the solution away from the medical profession because of the procrastination, if not the active resistance, of the profession.

"I am amazed to find, as I travel about this country and talk with physicians, how few of them realize just how close we are to some form of socialization of medicine. They have been drugged into believing that bills before the Congress are merely the ideas of crackpots which have no chance of ever becoming law. Nothing could be farther from the truth. The solutions introduced in the Congress may be unsound. They may not become law this year. But, just as sure as we are here together today, if medicine does not offer a workable solution to this real problem, some plan will be forced upon the medical profession. How much political influence do you think the medical profession has? . . . Why, all the doctors in the United States could not elect ten Congressmen!"

Dr. Hawley then proceeded to tell the doctors what they must do:

"It is the duty of medicine not only to offer the highest standard of practice, but to insure that this standard is available to every citizen. This is a problem for the medical profession to solve. American industry has reached its present preeminent position NOT by making the most expensive products in the world, but by making the best products in the world within the reach of practically every American family. It is a travesty upon sound social organization that families in the low income brackets can afford automobiles, but cannot afford good medical service. I know that there are some who would say that these people could afford good medical service if they did not own automobiles. But this retort is comparable to that of the Queen of France who said, 'If the people have no bread, let them eat cake.' The automobile is no longer a luxury. People should be able to afford both automobiles and good medical care. Now, American labor is by far the highest paid labor in the world; yet the products of American labor are among the cheapest as well as the best in the world. American industry has accomplished this by economies in production. I am not advocating that American medicine attempt assembly-line procedures; but I do insist that American medicine must effect comparable economies if it is to exist as a free and unregulated profession. That there are many extravagances in medical practice which have nothing to do with the quality of the practice is evidenced by the wide spread in the costs of operation of hospitals. Business methods MUST be applied to medicine without being permitted to degrade medicine. Doctors MUST be paid well. The lowering of costs of medical care should not, and need not, be made at the expense of the profession. But lower them we must, else we are all going to be working for the Government within a very short period.

"I suggest to you, then, that the profession re-define 'medical economics'—that the scope of medical economics

> be enlarged to include the financial responsibility of doctors to their patients instead of being restricted to the financial responsibility of patients to their doctors."

Among the solutions of which Dr. Hawley approved is one which he credits to Dr. Warren F. Draper, former Deputy Surgeon General of the United States Public Health Service. Dr. Draper, he said, pointed out "that the great increase in cost of medical care is almost exclusively confined to diagnosis. It is the ever-increasing necessary laboratory procedures that make the cost so heavy to the patient. Physicians' fees have not risen out of proportion to the general rise in incomes." So, Draper proposed "that any socialization or subsidization of medicine be in the field of diagnostic technics and that therapeutic measures remain within the province of private practitioners."

There has been much discussion of Dr. Hawley's address among doctors in Washington. Most of them are inclined to be critical. This may be laid, in some degree at least, to the fact that they had not read his address in its entirety. A newspaper article appearing on the morning following the address led off with this sentence, "Socialized medicine with all doctors working for the Government is sure to come if medical costs are not lowered soon." It will be seen from extensive excerpts from the address in this column that that is not what Dr. Hawley said. However, it is significant that Dr. Hawley should have made this speech, and doctors may well, in view of his position, give serious thought to his remarks.

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". . . Generalized Edema of the Ego. . ."

As a nation we cannot be said to be suffering from an inferiority complex. On the contrary, we are a confident and proud people. We proclaim to the world that we live in the greatest country on earth. Everything we have is the best, and that includes our medical institutions.

Not a few have been irritated by what they feel is our smugness. One of these is Dr. Edmund E. Simpson, who writes in the September issue of the *Journal of the Association of American Medical Colleges*, on the subject, "A Practitioner's Reaction to Trends in Medical Education." In emphasizing a point he wishes to make, Dr. Simpson says this:

> "We Americans are quite certain that everything in this country is either the biggest or the best, or both. Almost every issue of *Life* magazine contains one or more pictures of scenes native to this country and described as the biggest or most beautiful or the busiest in the world. This is not only utter nonsense but a gross distortion of a sense of courtesy and the proper fitness of things. We do ourselves no good in our relations with others in constantly bragging of our superiority. This general attitude pervades American medicine. The *Journal of the American Medical Association* frequently cites the excellence of American medicine and its superiority over that of all other countries. That we are, in fact, superior is open to question. Of the great men of medicine certainly far more have come from England and Europe (admittedly, particularly in the past). Although this might be due to our younger culture, or for whatever reason, we should not be blinded by narrow provincialism, as we now are, and we should concede, if need be, that others are as good, or even better, than we. And if we are superior we should have the good grace not to talk about it. It is this generalized edema of the ego which contributes to a lot of nonsense now put out about our schools, and we must return to a more sane outlook and broader, impartial view if our schools are to be made better."

Dr. Simpson finds many defects in our present method of training medical students. He quotes from an article by Charles Wilson, appearing in the *Journal of the British Medical Association* (1932), to make his first point:

> " 'It is nowhere denied that we ask impossible tasks of students, who are bewildered by hours of listening, and that we stamp out the habit of reflection by a ceaseless drill. And this is done in the name of education. . . . So strange an anomaly may set us thinking how we are come to such a pass. The blunt truth would appear to be that the handling and revision of the curriculum are based on a misconception of what we can and ought to attempt in a medical school. The one purpose of the student's years is, it seems, not to train and test habits of thought, but to collect and store a set of facts, as

> squirrels hoard the nuts on which they hibernate. . . . It may be conceded that such a policy was reasonable when medicine was a slowly progressing science that did not greatly alter in a man's lifetime. Today it leaves him bankrupt when he has scarcely begun. The little he knows is soon antiquated, and he cannot keep up with a rapidly changing science, for we have so contrived to educate him that he cannot educate himself. . . . We trust neither his industry nor his capacity. He must be driven into different pens for every hour of the day, along with a drifting flock that presses now this way and now that. And this, if I may be allowed to change a metaphor, in the hope that he may one day recognize a disease because he has seen it before.' "

Among other things, he laments the lack of "academic culture" among doctors.

> "Research," he says, "has become a fetish, but to argue that true research is nonsense would be absurd. Research is a necessary part of the activities of a medical school, not only to advance the front of medicine but to provide an atmosphere in which students may be stimulated to further effort, to afford them contact with great men, and to gain experience in the process of discovering. But research should be left to those who have the touch, the insight, the will to learn something new—and this can be done by the lonely practitioner in an isolated community as well as by those in beautifully appointed urban laboratories—and the publication of papers merely as a means of self advertisement or hopes of promotion should be decried. A man should publish when he has something to say and for no other reason."

The real object of education, Dr. Simpson says, is to be able "to tell the difference between what is true from what is apparently true."

* * *

Why the Layman Is Skeptical

There is nothing new about the observation that patients seldom associate their physicians with medical societies, of which they are not infrequently critical. Often the patient's high regard for his physician borders on adulation. It does not occur to him that the actions of the medical society usually conform to the expressed wishes of his doctor. What, then, is wrong with medical societies that they have not won the good will shown the individual physician? *The Journal of the Medical Society of New Jersey*, in the September number, has this to say:

> "The organized medical profession has never earned for itself the prestige and affection which the individual doctor enjoys. The practitioner needs no public relations program. The layman accepts the doctor of medicine as a scientist, a humanitarian, a gentleman and a scholar. Occasionally, he is none of these things, but until he proves himself otherwise, the public looks on a doctor with esteem, affection and sometimes even with veneration.
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> "The organized profession, however, enjoys no such universal public acclaim. The layman recognizes that the medical society has three functions: first, to study and disseminate scientific knowledge; second, to protect the community against quackery; third, to protect the welfare of its own members. We still have blue ribbon rating with reference to the first two functions. Even the severest critics of organized medicine agree on the efficiency of a medical society as a scientific sounding board and its honesty and usefulness as a warrior against charlatanism. But when the layman thinks of a medical society as an organization of doctors for their mutual protection, the criticism begins, and it is at this point that our public relations standing goes into a tail-spin.
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> "Of course we have a simple answer. We say that whatever is in the interest of the physician is in the interest of public health; if we guard the rights and privileges of doctors, we automatically guard public health. That's what we say. The layman does not believe it. He sees the doctor as a small businessman, assembling in his society, with other owners of small businesses. When retail merchants get together to form a league, the buyer begins to get worried. He assumes that whatever the purposes of such an organization, the protection of the buyer is not likely to be number one. We know that this analogy is all wrong, but we don't quite know what to do about it. Somewhere on the road between Dr. X as family practitioner and Dr. X as a representative of the medical society, that aura of confidence and esteem has been sidetracked."

The Journal observes that the public criticism of organized medicine falls into one of two categories, "There are those who think we are a sort of labor union; and on the other hand, those who think that organized medicine is a 'big trust.' Actually, organized medicine comes closer to the old idea of a guild than to the newer concepts of either labor union or monopolistic trust."

"Every doctor in the country has his quota of trusting patients, yet when you multiply the typical M.D. by a hundred thousand, and call him AMA, he suddenly becomes a trust or a labor union." No solution is suggested by *The Journal,* which concludes its observations with the question, "How can we show the public that the medical society is simply the plurality of the family doctors of America?"

At the risk of becoming a bore, your Observer wishes to repeat what he has said many times before. When organized medicine convinces the people that it is genuinely concerned with the economic problems incident to illness and offers an adequate nation-wide program to cope with them, it will no longer need to concern itself about public relations.

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There Should Be a Law

American audiences, whatever their shortcomings, are the world's most tolerant. Their patience seems inexhaustible. Especially is this true where speakers are concerned. They listen respectfully, even when the speaker has nothing to say. When he shows charts, objects and films which cannot be seen by the audience, they readily forgive him.

An example of the lack of consideration shown their listeners by speakers is the practice of physicians appearing before medical societies to show slides with such small print that the text cannot be seen more than a few feet away. Of course, the facts which the speaker wishes to convey are completely lost to the audience.

Your Observer is aware that he has had something to say on this subject before. But to date it has had very little effect. He now hopes, perhaps forlornly, that something will be done about this matter. Perhaps there should be a law, as the saying goes, regulating speakers. In the absence of such regulations, it is your Observer's suggestion that program committees of medical societies might well lay down rules which speakers be required to observe.

Your Observer does not want to seem to be an unpleasant sort of a fellow, but he hopes to convince the Program Committee of the Medical Society of the District of Columbia that it should require future speakers to use slides that can be easily read in the last row of the Society's auditorium, or none at all. This is not an unreasonable demand. As a matter of fact, there is no reason why slides cannot be made with large print. Understandable text matter would help, and over-technical graphs which mean little to the non-specialist might well be done away with.

Then, there is the speaker who talks in such a low monotone he cannot be heard. Since the public address system was installed in the Society's building, this is not a major problem. However, speakers forget and do not stay close enough to the microphone. The presiding officer can, of course, readily remedy this situation by reminding the speaker of the microphone.

Your Observer reserves his last criticism for doctors who speak to lay audiences and who do not take into account the fact that they are not familiar with medical terminology. Recently, your Observer was present when a physician used such words in speaking to a lay group as "therapeusis," "neoplastic disease," and "irradiation," to mention only a few. Now, how much simpler and understandable it would have been had he spoken of "treatment," "cancer," and the "use of X-rays." Before addressing a public gathering, the physician should endeavor to orient himself to the thinking of the lay person. Otherwise, his message will be entirely lost. And, incidentally, he will become a bore.

Your Observer has a few more complaints up his sleeve, but he will save them for another time.

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"The Lady Who Knows—"

Those who attended the hearings of the Senate Committee on Education and Labor last winter and spring will recall an alert, rather intense, graying woman always seated next to Senator Forrest C. Donnell of Missouri. She was Mrs. Marjorie Shearon, Research Analyst, Conference of the Minority of the United States Senate, who had been assigned the task of supplying the Senator with data and prompting him when questioning witnesses.

Mrs. Shearon was not always on organized medicine's side. For a number of years she was employed by the Social Security Board. She says that three and a half out of the five years with the Board she served under Isidore S. Falk, Director of the Bureau of Research and Statistics. In the course of this association she developed a bitter antipathy for Mr. Falk's views on medical care. Since leaving the Government, she has made her opinions known whenever the occasion offered.

Along in the early summer of 1946, Mrs. Shearon issued bulletins devoted to health legislation. These were more than factual reports. They indicated how deeply Mrs. Shearon felt about opponents of organized medicine. Medicine's cause became hers, and she had stronger convictions about what should be done than most doctors. Critical of the representatives of organized medicine, and especially those who she said were paid for the purpose of "guarding its interests," she warned that the medical profession is in "an extremely weak position in combating the forces now working for the destruction of the private practice of medicine."

What she called the House of Falk, however, was the principal object of her attack. Here she laid down her heaviest verbal barrage. Unfortunately, the length to which Mrs. Shearon went to discredit Mr. Falk invalidated some of her otherwise sound arguments.

Under date of August 9 she issued a bulletin in which she set forth at length her qualifications for the role in which she had been cast. These were impressive enough, and several medical societies invited her to speak to them. One of these was the Michigan Medical Society.

Albert Deutsch of the loud leftist newspaper *P.M.*, who baits organized medicine whenever the opportunity offers, covered the meeting addressed by Mrs. Shearon in Michigan. As usual, he went at his assignment without gloves. Mrs. Shearon, he cried, "put the finger on Fishbein and other alleged participants in this international plot," the plot being to turn the world over to "Joe" Stalin. Mr. Falk came in for special attention. "Now this fellow Falk," Mrs. Shearon is quoted as saying, "is the most dangerous man in America. He is very, very clever, and a master of intrigue." Michael M. Davis and others she considered "nearly as dangerous." Finally, according to Mr. Deutsch, she got around to Dr. Fishbein, who, she is said to have related, is often seen in Washington in company of known advocates of compulsory sickness insurance. "I don't trust Fishbein," she is reported as saying. In fact, she is said to have added that Dr. Fishbein and Mr. Falk are "like two peas in a pod. I would like to see them both dumped into the river."

Mr. Deutsch chided doctors present for applauding Mrs. Shearon's "flights into fantasy."

As these lines are being written, an announcement of Mrs. Shearon's appearance before another medical society came to your Observer's attention. She is listed on the program as "The Lady Who Knows the Sinister Implications of Socialistic Medicine."

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Homicides Increase As everyone knows, crime in this country has been on the increase ever since V-J day. Our newspapers have been filled with accounts of violence and destruction. Murders which would have made the front page a few years ago now rate only a small item buried on an inside page. The same is true of suicides, which reflect the disillusionment and emotional instability of many of our people. What are the reasons for this state of affairs?

The Metropolitan Life Insurance Company recently made a study of deaths from homicides among its policyholders. Its findings appear in its *Statistical Bulletin* for August, 1946, which states that each month since September 1945 has shown a higher homicide rate than the corresponding month of the preceding year. During the first six months of 1946, the rate was 4.2 per 100,000 policyholders, which was more than one third above the figure in 1945, and the highest in seven years. This trend is reflected in the general population of the United States. Latest reports show that the homicide rate for the first five months of 1946 was 5.2 as against 4.0 for the same period in last year.

In explanation of the postwar increase in homicides, the *Bulletin* says,

> "In the official figures for the general population of the United States, a part of the rise may well be attributed to the inclusion, in the records of the Bureau of the Census for 1946, of large numbers of returned veterans who, during the war years, were abroad, and hence not included in the official statistics for the United States population. These men are precisely in the age groups which normally contribute a large proportion of both the culprits and the victims of homicide. Obviously, however, this is not the entire explanation, for the mortality records of the Metropolitan Industrial policyholders, which include the men in service overseas, show the same trend. It seems likely, therefore, that there are some further factors operating. Among these may be the postwar letdown in national morale, particularly a natural unrest among discharged servicemen who, having completed a strenuous assignment under strict supervision, are suddenly left on their own resources and responsibility. Moreover, postwar job opportunities may have failed, in many instances, to come up to expectations. In addition, there is a wartime acquired familiarity with firearms and an unusual number of these, largely trophies or 'souvenirs' from the war, are available.
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> "Another possible factor, affecting more particularly the civilian population, may have been the postwar cutback in industrial employment and the discontinuance of civilian war activities. As a result of these developments, presumably people have had more time for petty quarrels and domestic disputes, which are the immediate cause of a large proportion of homicides."

The *Bulletin* concludes that "There is no simple solution to this complex problem. Further restricting the sale of firearms would undoubtedly have a salutary effect. More generally, greater efforts should be made to eliminate such environmental factors as poor housing, ignorance, and the lack of proper recreational facilities, conditions that encourage crime and antisocial behavior."

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Medical Plan Progresses

Organization of MEDICAL SERVICE OF THE DISTRICT OF COLUMBIA, the Society's new prepayment medical plan, will be completed before these lines appear. The plan has progressed slowly, through no fault of the Committee on Medical Care. Time-consuming procedures have of necessity had to be followed. These have often tried the Committee's patience, but there isn't much to do about it.

On September 18, at a special business meeting of the Society, twenty incorporators of MEDICAL SERVICE were chosen. Those elected were: Drs. Victor R. Alfaro, Joseph B. Bogan, Arthur C. Christie, William Earl Clark, Milton C. Cobey, Frank D. Costenbader, Sidney C. Cousins, Henry L. Darner, Harry F. Dowling, William T. Gill, Jr., William P. Herbst, Jr., Raymond T. Holden, Oscar B. Hunter, Sr., A. Magruder MacDonald, Paul S. Putzki, W. Warren Sager, Fred R. Sanderson, Maurice A. Selinger, Joseph P. Shearer and Donald Stubbs. Immediately following their election, the incorporators held a meeting, at which time they elected the seven members of the Board of Trustees who are to represent the Society. They are: Drs. Frank D. Costenbader, Sidney C. Cousins, Harry F. Dowling, William P. Herbst, Jr., Raymond T. Holden, W. Warren Sager and Maurice A. Selinger. Four members of the Board remained to be designated by the United States Public Health Service, the District Health Department, and the Washington Metropolitan Health Council. Dr. Thomas Parran, Surgeon General of the Public Health Service, promptly appointed Dr. G. Halsey Hunt to represent his department; Dr. George C. Ruhland, District Health Officer, agreed to serve as a representative of his department; and the Washington Metropolitan Health Council designated Mr. Howard Strong, of the United States Chamber of Commerce, and Mr.

W. Pierce MacCoy of the State Department, as its representatives.

Adoption of by-laws and election of officers will take place at the first meeting of the Board of Trustees, which will be held on October 29. Immediately thereafter, conferences will be held with officials of Group Hospitalization, Inc., for the purpose of discussing the business administration of the SERVICE by that organization. Upon completion of arrangements, there will be a period of preparation before actual operation begins.

Despite the many hurdles yet to be taken, it would appear that early in the new year MEDICAL SERVICE should be serving the community.

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Proud Vanderbilt It hadn't occurred to your Observer until recently how many of the AMA's topflight leaders have come from the South. This led to the discovery that Tennessee's Vanderbilt University School of Medicine had contributed the greatest number. A friend in the Midwest, who attended Vanderbilt several years ago, sent him the July-August 1946 number of *Vanderbilt Alumnus*. Featured in this issue was an article, "Vanderbilt Folk Prominent in the Medical World," by Elmer Hudgins.

> "The American Medical Association, most regnant of all physicians and surgeons' societies," Mr. Hudgins writes, "has long recognized the influence of Vanderbilt men in its own processes of advancement and, seemingly, endeavors to keep the key positions of the organization well staffed with them.
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> "In this year's elections of the AMA, Dr. Olin West, M'98, onetime adjunct professor of Chemistry at Vanderbilt, who has served as AMA secretary since 1923 and as secretary-general manager for the past several years, is being elevated to the presidency. He is the ninth Vanderbilt man to receive this honor."

Dr. Harrison H. Shoulders, President of the AMA this year, is also a Vanderbilt alumnus. He will serve until next June, at which time Dr. West will succeed him in office.

> "Once before in the history of the American Medical Association did a Vanderbilt man succeed another Vanderbilt man to the presidency. The late Dr. William D. Haggard, then professor of Surgery and Clinical Surgery in the School of Medicine, Vanderbilt, was elected for the term of 1924–25, immediately following that of the late Dr. William Allen Pusey, A.B.'85, A.M.'86, then professor of Dermatology of the College of Physicians and Surgeons of Chicago.
>
> "Dr. Paul Eve, Sr., was the first of the nine men associated with Vanderbilt Medicine to serve as president of AMA, his term being 1857–58. It was later, in 1875, that he became a member of the Vanderbilt faculty. Dr. William K. Bowling, founder of the *Nashville Journal of Surgery and Medicine* (1851) and one of the founders of the Medical Department at the University of Nashville (also 1851), served in 1874–75. His connection with the Vanderbilt School was not in an official capacity, but existed due to the close relationship of the Schools of Medicine of the two universities. Dr. William T. Briggs, professor of Surgery at Vanderbilt in 1878 and a founder of the American Surgical Association, served for 1890–91. Dr. John A. Witherspoon, faculty member from 1889 and professor of Medicine and Clinical Medicine at his death in 1929, served in 1913–14. Dr. Duncan Eve, Sr,. professor of Surgery at Vanderbilt from 1895 until his death in 1937, served in 1918–19.
>
> "These positions of trust and influence are not being bestowed so consistently by such an authoritative organization as the American Medical Association upon the men trained in a single institution without the weighing and calculation of past production. The trend is perhaps indicative of the major source of progressive thinking of the medical profession in the near future. Vanderbilt in bearing to the forefront here draws, to a certain degree, the entire South toward leadership of the nation. It is no mean accomplishment; it should be accorded no small honor."

Vanderbilt may well be proud of her sons.

★

When It Comes to Dues There would be cause for concern if medical societies did not have members who complained that their dues were too high. At least, wherever officers of medical societies meet, one gathers that this complaint is a very familiar one. Related are the kicks of those who are happy until billed for their dues. Then it begins. What do I get for my money anyway? I get the journal, and what else? Scientific meetings aren't as good as they were. What does the organization do with its money anyway? And so on, ad infinitum.

Your Observer has an idea that most of these complaints are not to be taken too seriously. Individuals making them must have something to talk about. For the fact is that the dues of most medical societies in this country are ridiculously low. It is also safe to assert that medical society members, by and large, get much more than they have a right to expect.

What is the situation in the District of Columbia? Undoubtedly, the Medical Society has its quota of those who are not happy about dues. On the other hand, your Observer is certain that not many medical societies in this country have received as enthusiastic support, financial and otherwise, as has the District Medical Society. Naturally, this has been most encouraging to the Society's officers, and has spurred them on to greater efforts.

Shortly there will be issued a pamphlet for the information of Society members, entitled, "What *You* Should Know About *Your* Medical Society." Included in the pamphlet will be a short history of the Society, a brief description of its scientific program, civic activities, and services it renders members. This information should prove helpful to members, and it should certainly enlighten them considerably as to the benefits which accrue to them because of their Society affiliation.

Your Observer hopes that all members will read the pamphlet carefully. He believes that they will be favorably impressed. Perhaps they will come to the conclusion some other medical societies have that, despite what has been and is being done, their investment is too meager to obtain all the results desired.

California physicians have realized that they must do more than they have in the past. More money, they decided, was needed to make an organization fully effective. So members of the California Medical Association voted to increase their dues to $100.00 annually.

Doctor, when you have recovered, think it over.

T. W.

CHRISTMAS SEAL SALE ENDORSED

In consideration of the importance of the public health of the community in general and, in particular, the problem of tuberculosis in Washington, I desire to voice the commendation of the Subcommittee on Tuberculosis of the Medical Society of the District of Columbia for the large and intensive program of tuberculosis prevention which is being done by the District of Columbia Tuberculosis Association.

At the request of the Tuberculosis Association, members of the Subcommittee examined the recent activities of the Association. The Subcommittee learned that by means of a wide and direct contact with the people of Washington and through close coöperation with public and private health agencies, the Tuberculosis Association with the funds from Christmas Seals is carrying on a far-reaching work.

That work includes research; professional, adult and school health education; information service, case finding and rehabilitation.

The Research Department studies various phases of the tuberculosis problem in Washington; prepares factual information for presentation to the public, both lay and professional; initiates and carries on investigation of the socioeconomic status of the tuberculosis population; compiles, analyzes and interprets statistical information about health problems in Washington with special reference to tuberculosis.

Through the Case Finding Service, annual chest X-ray examinations are promoted among employee groups, general hospital admissions and community groups. The health of employees generally is furthered by making available to employers current information on ways and means of improving health, thereby aiding in the protection of their future earning power and reducing lost work-time.

Professional Education includes participation in postgraduate seminars for physicians, promotion of special programs on tuberculosis for the Medical Society, promotion of special instruction and additional opportunity for nurses in training, and coöperation with the Health Department for in-service training programs for nurses.

The Information Service gives free, confidential advice to inquirers on problems relating to tuberculosis, many of whom are referred to their private physicians. It assists patients in making adequate plans for treatment and care, helps him and his family understand the disease and know the facilities available for care, not only in Washington but in his home community.

Adult Health Education promotes individual and group action in the prevention and control of tuberculosis and other public health problems through newspapers, radio, speakers, motion pictures, posters and pamphlets.

Child Health Education promotes training and instruction on health and tuberculosis for students and teachers in the public and parochial schools. Through the medical departments of colleges it promotes recognized procedures for the discovery of tuberculosis in college groups. Each year it sponsors X-ray examinations among public and private high school seniors and adult members of their households.

A program of Rehabilitation in the four local tuberculosis hospitals is aimed at the economic recovery of the tuberculous patient through education, training and job-finding assistance; the elimination of tensions and anxieties caused by the adjustment of the patient to the sanatorium; the development of leisure-time activities related to the physical condition of the patient; to help build hospital morale and discipline by means of reasonable activity; and to assist the patient in getting the full benefit of his cure by holding him for the full term of his treatment.

Therefore, the members of the Subcommittee on Tuberculosis of the Medical Society of the District of Columbia desire to express their appreciation of the services carried out by the Tuberculosis Association, and they hope that all citizens who can do so will assist in this protective community health work by buying and using as many Christmas Seals as possible.

J. Winthrop Peabody, M.D.
Chairman, Subcommittee on Tuberculosis

THE SAFEST INVESTMENT IN THE WORLD

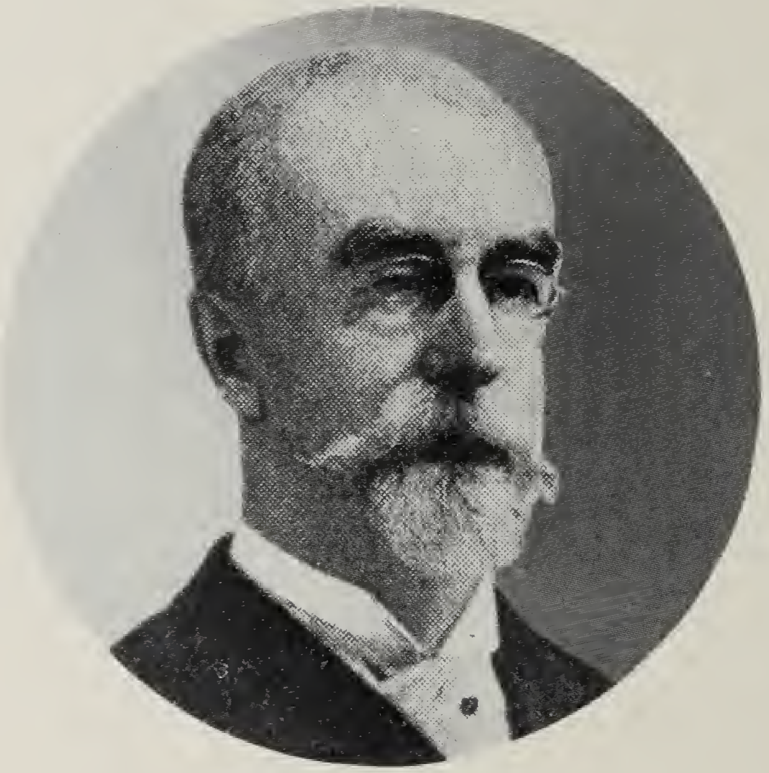
The record set by doctors in the District of Columbia in the sale and promotion of savings bonds has been officially cited by the United States Treasury. It is a record that has inspired other professional groups to emulate. It is a record of which we can all be proud. With that record as a backdrop, we are again being called upon by our Government to pitch in with support for the United States Savings Bond program.

Starting Armistice Day, and continuing through Pearl Harbor Day, the District Savings Bonds Division of the Treasury will conduct a promotion and publicity campaign to remind citizens that savings bonds are still on sale at their nearest post office, bank, or savings and loan association. There is a deeper significance, however, to the drive. The inflationary spiral continues to mount and the need grows greater day by day for the channeling of the dangerous money into savings bonds where it cannot compete for continuing scarce goods and thus contribute to the rising cost of those goods.

Now that controls are going by the board, it is smart for each and every one of us to push the

(*Continued on page 578*)

Washington Physicians of Yesterday



NATHAN SMITH LINCOLN, M.D.

One of the most distinguished physicians in Washington in the years immediately preceding the Civil War was Dr. Nathan Smith Lincoln. Not only did he attain a high standing as a physician, but he was descended from a prominent family, many of whose members had achieved distinction in both war and peace.

Dr. Lincoln's great-grandfather, General Jonathan Chase, drew up articles of surrender for Burgoyne's army at Saratoga, and General Benjamin Lincoln received the sword of Cornwallis at the Yorktown surrender. His grandfather, Dr. Nathan Smith, founded the medical schools at Yale and Dartmouth.

Born April 3, 1828, at Gardner, Massachusetts, Dr. Lincoln attended Dartmouth College, receiving his Bachelor of Arts degree in 1850, and Master of Arts degree in 1853. His medical degree was obtained at the University of Maryland in 1852. After his graduation, he practiced in Baltimore until January 1, 1854, when he removed to Washington.

Dr. Lincoln was elected Professor of Chemistry at Columbian Medical College in 1857, afterwards filling the chairs of Theory and Practice of Medicine, Anatomy and Physiology, and Surgery, holding the latter position until he resigned in 1874. In 1861 he was appointed Acting Assistant Surgeon in charge of the Quartermaster's Hospital in Washington.

He held many responsible positions in various medical organizations. He was Vice President of the Ninth International Medical Congress, 1887; President of the Medical Association of the District of Columbia, 1892–93; and President of the Alumni Association of the University of Maryland.

Thrice married, Dr. Lincoln's first wife was Mrs. Margaret E. Ridgate of Washington; his second, Mrs. Nannie Smith of Baltimore; and his third, Miss Jeanie Thomas, daughter of Judge George Gould of New York. He died October 14, 1898.

CONCLUSION OF A SURVEY OF BLUE CROSS AND MEDICAL SERVICE PLANS*

Louis S. Reed

Health Economist, Division of Public Health Methods, United States Public Health Service

In 1943 the Public Health Service decided that any health movement with as many participants as the Blue Cross Plans was worth knowing about. It wanted to learn about these plans, to appraise their advantages and limitations. The Blue Cross Plans wanted the Public Health Service to learn about them, and in addition they wished to know how they might be made more useful to the public. So a survey was arranged. The field work of that survey began in March 1944 and continued for a year. In all, 39 hospital plans and 17 medical plans were visited. By medical plan is meant plans affiliated with Blue Cross Plans or sponsored by medical societies or both. The hospital plans studied were selected so as to be representative of all the plans with respect to geographical location, size and other pertinent factors. The medical plans visited included all but one of the then existing plans.

The surveys of the individual plans took in all aspects of their operation and included interviews with hospital administrators, physicians, employers, labor union officials and representatives of hospital councils, medical societies and civic organizations, to learn their attitude toward the plans. The surveyed plans gave full coöperation, and I should like to take this opportunity to thank the executive directors and the staffs of these plans for their aid and courtesy.

The report setting forth the findings of the survey is now close to completion. Its conclusions are in process of joint review by advisory committees of the plans and the Public Health Service. The report, which will constitute a large volume, will be completed early in the winter and will be published, it is hoped, as an official bulletin of the Service.

What follows constitutes a preliminary statement of the conclusions of the survey.

There are 81 Blue Cross hospital service plans in this country. They have a total enrollment of 22,000,000. All but four states have all or part of their area served by plans. The percentage of the population enrolled in the various states ranges from 62 per cent to zero. The first of these plans was established in 1932 but it was only in 1937—nine years ago—that enrollment passed the million mark.

Nine Blue Cross Plans have expanded their service to include certain physicians' services—generally surgery and obstetrics only. These plans are no longer hospital service plans; they are hospital-medical plans.

There are now 31 separate medical plans. These have an enrollment, including the medical enrollment of the hospital-medical plans, of approximately 3,200,000. Plans which offer medical coverage now exist in 29 states. The percentage of the population enrolled varies from 31 per cent to zero. The plans cover surgery and obstetrics or these services and medical calls in the hospital. A few also cover home and office calls. In point of number most of the plans are on a straight indemnity basis, i.e., they provide benefits in the form of dollar allowances or credits against the physician's bill. However, the majority of the subscribers are in plans which are on a mixed service and indemnity basis, i.e., which provide service benefits to subscribers with incomes under certain levels and indemnity allowances to those above this level. Four plans provide service benefits to all subscribers without regard to income.

With three or four exceptions all of the separate medical plans are allied with the hospital plan serving the same area. The two plans each are set up as separate corporations with separate directing boards but they are, in whole or in part, jointly administered.

The movement to establish medical plans began for all practical purposes in 1939. At first, growth was slow; the medical profession was not greatly interested in such plans. However, since 1943 the medical profession has shown great and increasing interest in establishing these plans, and growth in number of plans and enrollment has accelerated. At present, in virtually all of the states without medical plans, the medical profession is working to establish one. By another two or three years hospital and medical plans or combined hospital-medical plans will probably exist in all states. The operation of allied hospital and medical plans creates pressures leading toward their merger, and it is probable that in a few years most of these plans will be unified.

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* Address delivered at the Convention of the American Hospital Association in Philadelphia, Penna., October 1, 1946.

Such are the plans which have been surveyed. The question is, how good are they? To what extent do they meet or are they potentially capable of meeting national health needs?

The first conclusion of the survey is that the plans are beneficial for the subscribers, the hospitals, the medical profession and in some degree to the general public. The plans enable their subscribers to pay for the covered hospital and medical services in a convenient manner. They give protection against the possibility of heavy sickness costs. They enable the subscribers to secure the covered services promptly when needed and make it possible for a certain proportion of people to obtain care who, in the absence of this protection, would go without or would have to ask for charity. The patient who knows that his hospital and doctor's bills will be paid by the plan is in a frame of mind more conducive to recovery than the patient who is worrying over how these bills will be met.

The plans are good for the hospitals and the medical profession because they facilitate service to the public. They tend to remove the financial element from the relationship between those giving and those receiving service. The plans enable hospitals and physicians to secure fair remuneration for their services from some people who, without the plan, would be able to pay little or nothing. Thus they tend to increase and stabilize the incomes of hospitals and the profession.

The plans are beneficial for the general public because, as their enrollment expands, they tend to lessen the need for charity care which must be provided either at the expense of the taxpayer or through increased charges to paying patients. Thus the plans provide a broader and more equitable basis of financial support for hospital and medical service. Hospital plans increase the ability of communities to support hospital facilities; undoubtedly, medical plans, when they have large coverage, will increase the ability of communities to support the medical personnel they need.

The basic formula of the plans—non-profit status, free choice of hospital and physician and the right of all qualified hospitals and physicians in the area to participate—is sound and permits indefinite extension of enrollment.

The plans with their large enrollment are rendering an important contribution to the health and security of the population, and those responsible for this development—a truly amazing one—have every reason to be proud of their accomplishments.

Do the plans have the potentiality of being able to meet national health needs?

An answer requires definition of national health needs. It appears that the public wants and needs prepayment arrangements providing a comprehensive service—just how comprehensive is not clear, but probably hospitalization, physicians' service, nursing and dental care. The prepayment arrangements must assure service of good quality and the service must be organized and delivered efficiently. The prepayment arrangements should, as regards the economic and fiscal aspects, be responsive to public will, i.e., controlled by the public. Finally the whole population should be covered—adequate care made available to all.

When we compare the present plans with this ultimate objective—and it is an objective which virtually no country in the world has been able to achieve completely, and which under any circumstances could not be completely achieved in this country in any short period of time—it is apparent that the plans fall short in important respects. Let us consider the matter in more detail.

The objective is a comprehensive service. The present plans provide only a limited coverage—hospitalization, surgery, obstetrics and, to some extent, medical calls in the hospital. However, it is true that the plans have expanded the scope of their services in the past, and that eventually they might be able to provide a comprehensive service. However, this evolution, at the present rate of developments, would probably take quite a long period of time.

In line with this objective, prepayment benefits should be in the form of service. Indemnity allowances against hospital and practitioners' charges do not provide a complete or satisfactory protection. The present hospital plans do provide their benefits very largely on a service basis, but to a considerable extent the medical plans only provide their benefits on an indemnity basis. However, with full coöperation from the medical profession, medical plans could soon place their benefits on a full service basis.

Health services provided under prepayment should be of excellent quality and should be furnished efficiently. The present plans affect very little the quality of hospital or medical service or the ways in which hospitals and physicians provide their services. In general they merely pay hospital and physicians' bills—leaving hospitals and physicians very much as in the absence of prepayment. However, any prepayment plan which provides benefits on a service basis cannot avoid responsibility for the quality of service provided to its subscribers or for seeing that care is provided effectively. Any prepayment plan with large population coverage cannot avoid affecting the quality of service—for good or evil. As an example of this, consider hospital prepayment. In many localities the plans are providing 50 per cent or more of the income of their member hospitals. As population coverage expands toward 100 per cent, the basis of remuneration of hospitals will tend more and more to be in terms of the remuneration needed to meet the total maintenance costs of the institution. And remuneration in these terms cannot be divorced from questions of quality of service and efficiency in operation. Similarly any medical prepayment plan which achieves large population coverage cannot avoid concerning itself with the quality of service, the control of excessive or unnecessary services, and the effective organization of physicians to provide service.

But again the achievement of the objective, if the plans are left to themselves, will be apt to take a very long period of time.

The ideal is that the economic and fiscal aspects of prepayment should be under the control of the public, for after all the purpose of prepayment is to serve the public, and the public foots the bill.

The plans as they now stand are deficient in this respect, hospital plans less so than medical plans. Hospital plans are governed by boards generally selected in the last analysis by the hospitals and the medical profession of the area, or self-constituted. Because hospitals have generally selected as their representatives on plan boards outstanding civic leaders, who have viewed their obligations to the general public as paramount, it results that in practice there has been a large measure of public participation in the control of hospital plans. Medical plans, on the other hand, frequently have no or few lay persons on their boards but are controlled entirely by the medical profession.

However, while this is true it is also true that the control of these plans could be readily changed so as to give adequate representation to the public of the area. Hospital plans in the last few years have taken important steps toward giving the public a greater voice in their control.

Finally, the objective is that prepayment coverage should be universal, that comprehensive care should be made available to everyone. What are the enrollment potentialities of the plans? Will they be able to enroll the whole population?

The Blue Cross Plans have gone further than their fondest supporters ten years ago dared hope for. The plans have now enrolled about 17 per cent of the civilian population. During the first six months of this year they increased enrollment at the rate of about 4.5 per cent of the population a year. In some states the plans are enrolling the population quite rapidly—in Rhode Island at the rate of over 20 per cent of the population a year; in Massachusetts at over 10 per cent of the population a year. The growth of enrollment in the states with the highest percentage of the population enrolled shows no decline in the rate of enrollment, rather an acceleration. In many urban and rural communities in the northeastern and Middle Western states—communities in no wise different from other communities in the same regions—the plans have enrolled 50 or 60 per cent or more of the total population. On the other hand, in the South the plans have been making but small progress and only a tiny fraction of the population is enrolled. Taking all factors into consideration, it appears that the plans have large enrollment potentialities.

Medical prepayment is in its infancy. In a few states enrollment for medical benefits is approaching enrollment for hospital benefits. In general medical prepayment is at about the same stage of development as hospital prepayment was in 1938 or 1939. If medical plans place their benefits on a full service basis, if they give the public an adequate share in their control and thus achieve a status as community agencies, if they are unified with hospital plans, medical prepayment would seem also to have large enrollment potentialities.

The obstacles to complete enrollment of the entire population are the present defects of the plans, the fact that a considerable share of the population is unable to afford the subscriptions costs (and this share of the population is greater the more comprehensive the scope of benefits), the fact that many who could afford prepayment through ignorance, indifference or inertia will not avail themselves of it, and finally, that the processes of education which the plans conduct through their enrollment campaigns are necessarily limited and much time will be required to enroll all those who could be enrolled.

Consideration of these factors indicates that the plans by themselves will not be able to enroll the entire self-supporting population in any reasonable period of time or ever, though in some states they may make appreciable headway in that direction. However, it is also true that certain governmental measures would enable the plans greatly to increase their enrollment.

The Blue Cross Plans have suggested federal grants-in-aid to state-approved voluntary plans. Some Blue Cross leaders have suggested that Government might require certain groups of the population to enroll in prepayment plans (people being free to select the plan of their choice) and that employers be compelled to pay part of the subscription cost. Such measures, which clearly would affect the nature and status of the plans in important ways, might conceivably enable the plans to reach virtually the entire population.

From this appraisal it is apparent that the plans, by themselves, do not have the potentiality of achieving the ultimate objective—of bringing adequate comprehensive health services to the whole population. But it is also conceivable that with a high degree of governmental coöperation and assistance, the plans might be able to achieve the goal in mind. Whether such course of action on the part of Government is appropriate and represents the best and most effective way in which Government can act to bring adequate health care to the entire population, is outside the purview of this study. But these possibilities cannot be neglected in any appraisal of the ability of the plans—as they are now or as they might become—to serve the population.

In any case, the findings of the survey suggest that planning for the health care of the population must take the plans into account. If the states of Rhode Island and Massachusetts, for example, in which the hospital plans have enrolled 62 and 41 per cent, respectively, of the state population, were to consider what measures they could take to bring adequate hospital and medical care to their entire populations, it would seem that the existing plans must occupy a central place in their considerations. These plans are going concerns which have the confidence of the public, the hospitals and the medical profession. They have staffs skilled in the operation of prepayment and the payment of hospitals and physicians; they have reserves which are by no means trifling; and they could not suddenly be displaced or liquidated without considerable inconvenience to their subscribers, the hospitals and the medical profession. Just how in these states where the plans have become important they might be used, supplemented or built upon in any governmental program or in any coöperative program of Government and the plans, if such course of action were found desirable, is again outside the scope of this report. In this sense, the report raises more questions than it answers. It may be suggested, however, that the problem is one which deserves an increased measure of attention.

MEETINGS

Wednesday, December 11

Harold J. Jeghers, M.D., F.A.C.P., will speak on "Interpretation of Color of the Skin in Disease." Dr. Jeghers is Professor and Director of the Department of Medicine of Georgetown University School of Medicine.

MEMBERSHIP

The following applicants for membership will be voted on at the meeting of the Executive Board, December 16, 1946:

For Active Membership

Louis K. Alpert, Yale University—1932
Thomas McDowell Anderson, Harvard University—1931
Frank S. Bacon, University of Minnesota—1930
Sidney Berman, Georgetown University—1932
Brian Brewer Blades, Washington University, Mo.—1932
John Francis Brennan, Jr., Georgetown University—1941
Joseph Gerard Burd, Georgetown University—1938
Philip Burka, Georgetown University—1940
Rex Ernest Buxton, University of Michigan—1934
John J. Calarco, Georgetown University—1938
George Junior Cardany, Georgetown University—1938
Joseph Michael Cocimano, University of Maryland—1937

Maynard Irving Cohen, Johns Hopkins University—1940
William H. Devlin, Georgetown University—1942
Elbert White Dodd, Jr., Medical College of Virginia—1936
Reaumur Stearnes Donnally, Johns Hopkins University—1943
Joseph Aloysius Dugan, Georgetown University—1941
Henry Dunlop Ecker, University of Virginia—1940
John Anthony Farrell, Northwestern University—1940
Julius Fogel, University of Virginia—1937
William Dyer Foote, Georgetown University—1938
Maurice H. Friedman, University of Chicago—1932
Landon G. Gant, University of Nebraska—1931
Jules Gilbert, St. Louis University—1932
Leonard Gilman, Tufts Medical School—1938
David Stuart Gordon, George Washington University—1944
Everett Julius Gordon, Jefferson Medical College—1937
Isaac Solomon Grisoff, University of Alberta, Canada—1929
Aubrey Otis Hampton, Baylor University—1925
William Henry Hanna, Cornell University—1935
Dean Herbert Harding, University of Kansas—1943
John Harrell Hill, University of Virginia—1938
Thomas A. N. Hindman, University of Pittsburgh—1938
Hugh Wagner Irey, George Washington University—1939
Robert Toombs Jackson, University of Georgia—1941
Daniel Solomon Jaffe, George Washington University—1938
Robert E. James, University of Southern California—1940
Joseph Thomas Jana, Jr., Georgetown University—1940
Harold Joseph Jeghers, Western Reserve University—1932
Charles W. Jones, University of Maryland—1939
Herman Kabat, University of Minnesota—1942
Paul Joseph Kelley, Georgetown University—1938
Calvin Trexler Klopp, Harvard University—1938
Elizabeth Adams-Koppel, College of Medical Evangelists—1942
Harold James Kurtz, George Washington University—1942
Justin Everett Lacy, Vanderbilt University—1901
John Wilmer Latimer, Jr., George Washington University—1940
Mark Hummer Lepper, George Washington University—1941
Francis A. McDonald, Georgetown University—1931
Morris I. Michael, George Washington University—1942
A. Burton Mincosky, George Washington University—1942
Lloyd Harvey Mousel, University of Nebraska—1930
Leo Harold Mugmon, George Washington University—1941
James Peter Murphy, Yale University—1939
John Condron Murphy, Yale University—1940
Stanley L. Olinick, University of Buffalo—1940
Edward Anthony Palank, Georgetown University—1943
Eugene Adrian Patouillet, Georgetown University—1943
Norman Paul, Lausanne University, Swtz.—1936
Carey Moss Peters, Harvard University—1936
Andrew G. Prandoni, Long Island College of Medicine—1938
George J. Prenatt, Marquette University—1942
John Christian Ransmeier, University of Chicago—1937
Isadore Rod, George Washington University—1930
Robert Leo Roy, Georgetown University—1944
William Thomas Saccardi, Georgetown University—1940
Aaron Gilbert Saidman, George Washington University—1940
Julius Schreiber, University of Cincinnati—1932
John Norman Shadid, American University of Beirut, India—1941
Morris Silverman, George Washington University—1933
Arthur I. Simms, Jefferson Medical College—1939
Louis Cotten Skinner, Jr., Johns Hopkins University—1940
Max Howard Skolnick, University of Michigan—1932
Frederick Daniel Suttenfield, George Washington University—1937
Celia White Tabor, Columbia University—1943
Oswald V. Todd, Northwestern University—1938
Sophie Clara Trent, Yale University—1943
Charles P. Waite, Georgetown University—1926
Donald Walters, University of Virginia—1943
Wendall Melvin Willett, University of Chicago—1934
Prentiss Willson, Jr., Duke University—1940
Edward Comstock Wilson, Jr., George Washington University—1939
George Marvin Wyatt, Western Reserve University—1933
Irwin I. Yager, University of Berne, Swtz.—1935

For Associate Membership

Samuel Allen, Ohio State University—1939
Merrill Miles Cross, University of Vermont—1937
Julius Kauffman, George Washington University—1941
Marion Reginald King, Stanford University—1917
Mark L. Stone, University of Illinois—1938
Edwin Richard Weinerman, Georgetown University—1942
Blanche B. Wilcox, Ph.D., George Washington University—1932
Frank Anthony Zack, University of Maryland—1937

BOOKS RECEIVED FOR REVIEW

Acknowledgment is made of the following books which have been received for review.

The Challenge of Polio—the Crusade Against Infantile Paralysis. ROLAND H. BERG. Price, $2.50. Pp. 208. New York: Dial Press, 1946.

Medical Uses of Soap, 2d printing with a new chapter on "The Surgical Uses of Soap," edited by MORRIS FISHBEIN, M.D. Price, $3.00. Pp. 195 with 41 illustrations. Philadelphia: Lippincott, 1946.

Acknowledgment is also made of the following reference books:

Three Unpublished Drawings of the Anatomy of the Human Ear by the late MAX BRÖDEL, assisted by P. D. Malone, Stacy R. Guild and S. J. Crowe. Philadelphia: Saunders, 1946.

Collected Reprints of Thomas S. Cullen, M.D., Vol. IV Baltimore, Md., 1946.

News and Personals

The Annual Conference of State Secretaries and Editors will convene at the offices of the American Medical Association in Chicago, December 7 and 8, 1946. Dr. Wallace M. Yater, Editor of the Medical Annals, and Theodore Wiprud, Managing Editor of the Annals and Secretary of the Medical Society, are planning to attend.

The Scientific Exhibit at the Centennial Session of the American Medical Association, to be held in Atlantic City, N. J., June 9 to 13, 1947, will include both the history of medicine during the past century and the latest developments of medical science.

Application blanks for space should be procured as soon as possible from The Director, Scientific Exhibit, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois. Applications close on January 13, 1947, after which time the Committee on Scientific Exhibit will make its decision and notify the applicants.

The American Academy of Allergy will hold its annual convention at Hotel Pennsylvania, New York City, November 25–27, inclusive. All physicians interested in allergic problems are cordially invited to attend the sessions as guests of the Academy without payment of registration fee. The program has been arranged to cover a wide variety of conditions where allergic factors may be important. Papers will be presented dealing with the latest methods of diagnosis and treatment as well as the results of investigation and research. Additional information may be obtained by writing to the Chairman on Arrangements, Dr. Horace S. Baldwin, 136 East 64th Street, New York City.

The Silver Spring Academy of Medicine is holding regular meetings on the first Monday evening of each month at 8:00 p.m. between September and May at the New Montgomery County Building, Colesville Road, near the corner of Georgia Avenue, in Silver Spring, Md. Physicians who are practicing in nearby areas and who are members of either the Montgomery County Medical Society or the Medical Society of the District of Columbia are invited to attend.

Calendar of Meetings

October 4	Grievance Committee
October 13	Subcommittee on Maternal Welfare
October 16	Scientific Meeting of Society
October 17	Section on Neurology and Psychiatry
October 18	Committee on Cancer Control
October 21	Medical Bureau Committee
October 22	Subcommittee on Tuberculosis
October 23	Special Business Meeting of Society
October 28	Executive Board
October 29	Committee on Service Physicians Board of Trustees of Medical Service
October 30	Scientific Meeting of Society

Dr. Brian B. Blades, Professor of Surgery, George Washington University School of Medicine, will be the speaker on December 2; his subject, "Vagotomy in the Treatment of Peptic Ulcer." Speakers and titles of papers for subsequent meetings will be announced in the Medical Annals during the next few months.

The Sections on Neurology and Psychiatry of Philadelphia, Baltimore and Washington will hold a joint program and banquet at the Mayflower Hotel, January 10.

Co-hosts to the first meeting of the **Society of the United States Medical Consultants of World War II** were Major General Norman T. Kirk, Surgeon General, United States Army, and Brigadier General George C. Beach, Jr., Commanding General, Army Medical Center and Walter Reed General Hospital. The meeting, which was held in the Sternberg Auditorium at the Army Medical Center, October 18, was attended by approximately 90 physicians.

The Society is composed of the doctors, formerly medical officers and now returned to civilian life, who were consultants for the Army Medical Department in the Surgeon General's Office in overseas theaters and in the Zone of Interior during the war. They represent the leading men in their specialized fields.

The group has formed this association under its own initiative and with the purpose of furthering the advance of the medical profession in the United States, with the particular objective of establishing a close liaison with Army medicine. Its plans are still in the formative stage, and one aim of this meeting was to set up a working mode of procedure which will enable them to carry out their objectives.

The meeting was opened by an address by the President of the Soiciety, former Brigadier General Elliott C. Cutler, now of Harvard University. General Kirk paid tribute to the men whom he considers to have been highly instrumental in the record established by the Medical Department during the war, with its outstandingly low death and disease rate, stating, "I am most grateful that this organization has been formed. I am sure that you can be as much help in peace as during the war, in assisting the Medical Department of the Army to get the necessary things done, and to be prepared, if another war comes, to carry out the job."

Officers elected were as follows: Dr. Walter Bauer, Boston, *President;* Dr. Frank B. Berry, New York City, *Vice President;* Dr. Brian Blades, Washington, *Secretary;* Dr. Donald M. Pillsbury, Philadelphia, *Treasurer.*

The campaign to raise $925,000 with which to equip the new **George Washington University Hospital** got under way at an organizational dinner meeting at the Mayflower Hotel, October 7. About 400 community leaders attended the dinner.

The meeting was sponsored by the University's Board of Trustees in order to complete plans for the campaign. Initial contributions will be sought from alumni and friends, and public contributions will be solicited later.

Among the speakers were Dr. Claude W. Munger, Medical Director of St. Luke's Hospital, New York City; Vice Admiral Ross T. McIntire, Surgeon General of the Navy; Commissioner Guy Mason; Dr. Cloyd H. Marvin, President of the University; Dr. Walter A. Bloedorn, Dean of the School of Medicine; Robert V. Fleming, Chairman of the University's Board of Trustees, and Major General U. S. Grant III, Chairman of the Equipment Fund Committee, who also presided at the dinner.

General Grant has named Dr. Charles Stanley White as Chairman of the Medical Alumni Committee of the Hospital Equipment Fund.

In a radio round table disucussion over WRC, September 24, innovations in the maternity department of the new Hospital were described. Participants were Dean Bloedorn; Dr. P. A. McLendon, Professor of Pediatrics, and Dr. John Parks, Professor of Obstetrics and Gynecology, of the Medical School; and Leo G. Schmelzer, Superintendent of the University Hospital.

Over 500 physicians and friend gathered at Doctors Hospital, October 4, for the formal opening of the **William Mercer Sprigg Memorial Library.** The new library has acquired 500 selected new texts and medical reference books and files of 70 current professional journals, covering every specialty. In addition, interlibrary loan privileges have been arranged with the Army Medical Library and the Library of Congress.

A bronze memorial plaque bears the likeness of Dr. Sprigg in bas relief. Dr. Sprigg, who pioneered in the movement to construct the Medical Center, served on the Board of Directors of Doctors Hospital and was on the attending staff there for many years.

The library is supervised and directed by the Board of Trustees, composed of Dr. Harry Lee Claud, President; Dr. Oscar B. Hunter, Vice President; Dr. Edgar A. Bocock, Secretary-Treasurer; Drs. Charles S. White, William Earl Clark, Charles W. Hyde, Alan J. Chenery, Edgar P. Copeland, Fred A. Moss, Ralph M. LeComte, R. K. Thompson, Arnold McNitt, R. Lyman Sexton, Garnet W. Ault, Arthur C. Christie, Paul S. Putzki; and Mrs. Lois Sprigg Hazell, daughter of the late Dr. Sprigg.

Mrs. L. Dinwiddie Roberts is librarian and Mary J. Beers, assistant librarian.

The library will be open from 8:30 a.m. to 5:00 p.m. daily and from 7:00 to 10:00 p.m. each Monday Tuesday, Wednesday and Friday. Its facilities are available to the house and visiting staffs of

Doctors Hospital and the medical profession of the District. Research and bibliographies will be done for physicians on request.

Dr. David M. Levy, New York psychiatrist, has been named the **Salmon Lecturer for 1946** by the Salmon Committee on Psychiatry and Mental Hygiene of the New York Academy of Medicine. His lectures on "Excursions in the New Fields of Psychiatry" will be given on three successive Wednesday evenings, Novermber 6, 13, and 20, in the New York Academy of Medicine Building, 2 East 103rd Street, New York City. Members of the medical profession and friends are invited to attend. Dr. Levy has made outstanding contributions to the development of the child guidance movement and has played an important part in war psychiatry.

The 53 physicians who journeyed to the Congressional Country Club on October 3 to take part in the **Sixth Annual Physicians' Golf Tournament** were rewarded with ideal weather and satisfactory arrangements for their comfort and pleasure. In addition, there were prizes for every player.

The following is a list of the prize winners:

1st low gross, Joseph P. Kenrick; 2d low gross, James P. Stanton; 3rd low gross, E. Kirby Smith; 4th low gross, Howard L. Smith; 1st low net, Ham Underwood; 2d low net, Frank D. Costenbader; 3rd low net, Hugh O. House; 4th low net, Clayton Hawfield; 5th low net, Richard L. Spire.

Blind bogie: score 76, James P. Kane; 79, Milton L. Goldman, Harry F. Anderson, Weston Bruner, William R. Perkins, Jr.; 74, Charles P. Millwater, C. Edwin McNamara, George Berry; 73, Frank M. Hand, Leo B. Gaffney, R. C. Rounds, Don Johnson, Richard T. Kreuzburg; 71, Luther W. Gray, Edward B. Yonkers, H. Franklin Kreuzburg, William M. Ballinger;, 72, A. Sailer, Alfred C. Norcross, A Frank Kreglow; 77, Allen S. Lloyd, Leonard S. Berman, Don McKenzie; 75, Sherman A . Thomas, Edward J. Cummings; 78, James A. Dusbabek; 80, Joseph P. Shearer, Frank J. Eichenlaub, Harold A. Craft; 81, Philip J. Lowenthal, Richard J. McNulty; 82, Roy F. Dunmire; 83, James M. Moser; 84, Philip O. Pelland; 86, Richard T. Sullivan; 88, Philip A. Caulfield, Julius J. Radice.

Highest Score, Francis J. O'Brian; highest on any hole, Frank E. Gantz.

Firms which contributed prizes were as follows:

Teunis Opticians, George A. Breon & Company, H. LaFay Corwin, S. G. Leoffler Operating Company, East Capitol Pharmacy, Good Hope Pharmacy, Wilkins Coffee and Tea Merchants, Lincoln Park Pharmacy, Gibson's, Peoples Drug Stores, Beuchler's, Franklin & Strunk, Tipton & Myers, Kloman Instrument Company, Tschiffely Brothers, Williams Drug Store, Twigg, Mr. Troxler (Philip Morris), Camel Cigarettes, Lee Funeral Home, Tiralla, Hoffmann-LaRoche, Inc., and Doak Company.

The 123rd academic session of **George Washington University School of Medicine** opened Monday, September 30, at 11 a.m. Dr. Cloyd Heck Marvin, President of the University, made a short address of welcome. Dr. Walter A. Bloedorn, Dean of the Medical School, presided at the exercises and introduced the principal speaker, Major General Paul R. Hawley, Chief Medical Director of Veterans Administration. Dr. Bloedorn announced that grants aggregating $126,210 for research had been made available to the Medical School. Following the ceremonies Dr. Bloedorn was host at a luncheon at the Mayflower Hotel in compliment to General Hawley.

At the meeting of the **Executive Board,** September 23, two additional committee appointments, submitted by President Herbst, were approved. **Dr. James A. Gannon** was appointed to the Committee on Radio Education and **Dr. Don S. Knowlton** to the Committee on Public Policy.

Drs. Richard T. Sullivan and J. Ross Veal were reappointed Delegates to the Federation of Citizens' Associations of the District of Columbia for the coming year.

The District Medical Society was well represented at the **51st Annual Session of the American Academy of Ophthalmology and Otolaryngology,** which was held at the Palmer House, Chicago, October 13 to 18, 1946. In attendance were Drs. Victor R. Alfaro, Samuel A. Alexander, Sterling Bockoven, Jeter C. Bradley, Frank D. Costenbader, Joseph Dessoff, William D. Foote, James N. Greear, Jr., Dorothy Holmes, Bernard J. Gurwin, Benjamin Rones, Leroy L. Sawyer, J. Thomas Schnebley, Ernest Sheppard, G. Victor Simpson, M. Noel Stow, and Richard Wilkinson.

Drs. Rones, Costenbader and Sheppard assisted in presenting an instruction course on orthoptics. Dr. Rones with Mrs. Helenor Campbell Wilder, of the Army Medical Museum, presented a paper on "Nonperforating Ocular Injuries in Soldiers." Miss Mary Kramer of Washington read a paper on "The

Significance of a Vertical Component in Squint," which was discussed by Dr. Sheppard. Drs. Costenbader, Greear and Rones discussed other papers presented during the meetings.

Dr. Fred A. J. Geier was host to the **Section on Gastroenterology** at his home, October 14. Buffet supper preceded the scientific meeting. Dr. Tilden Howard of Johns Hopkins Hospital discussed the medical management of peptic ulcer, while Dr. Brian Blades, Professor of Surgery, George Washington University School of Medicine, presented the surgical treatment, including vagotomy.

The Section on Neurology and Psychiatry met October 17 in the Society's Library. The following program was presented: "Etiology of Essential Hypertension and Appropriate Treatments," Dr. O. Hugh Fulcher; "Extirpation of the Cortical Area as Defined under Conditions of Primary Facilitation," Drs. J. P. Murphy and Roman Arana.

The following medical officers, members of the Medical Society, having recently been separated from military service, are now back in practice in Washington and vicinity:

Worth B. Daniels, 1150 Connecticut Avenue, N. W.
Michael P. DeVito, 1801 K Street, N. W.
Clayton B. Ethridge, 1801 Eye Street, N. W.
Herbert A. Goldberg, 2517 39th Street, N. W.
Charles F. Hill, 1801 K Street, N. W.
William J. P. Howard, 1331 Trinidad Avenue, N. E.
John A. Kennedy, 4105 Wisconsin Avenue, N. W.
Emmett P. Madigan, 1835 Eye Street, N. W.
George A. Resta, 2927 Pennsylvania Avenue, S. E.
Raymond L. Schwartz, 1015 North Highland Street, Arlington, Va.
Samuel Shwartz, 1028 Connecticut Avenue, N. W.

Dr. Ben Klotz can be addressed at 817 St. Paul Street, Baltimore 2, Maryland. Lt. Colonel John F. Dominick will continue in service. He is in the Professional Division of the Air Surgeon's Office as Chief of the Surgical Branch.

The Medical and Chirurgical Faculty of the State of Maryland held its semi-annual meeting at the Manor Club of Montgomery County, Norbeck, Md., on October 10, 1946. Dr. Emil G. Bauersfeld, President of the Montgomery County Medical Society, gave the address of welcome. Two members of the District Medical Society participated in the scientific session, Dr. Mark P. Schultz, Senior Surgeon, U. S. Public Health Service, who discussed "Rheumatic Fever," and Dr. Charles S. White, who spoke on "The Use of Amino Acids in Surgery."

The Clinico-Pathological Society met October 15 at the Metropolitan Club, with Dr. Arch L. Riddick as host. The following program was presented: "Case of Transfusion Oliguria," Dr. John H. Lyons; "Tularemia—Unusual Initial Lesion—Streptomycin Treatment," Dr. John Minor.

The following officers were elected:

Dr. John Minor, *President;* Dr. Daniel B. Moffett, *1st Vice President;* Dr. Arch L. Riddick, *2d Vice President;* Dr. Theodore J. Abernethy, *Secretary-Treasurer.*

The first meeting of the **District of Columbia Rheumatism Society** was held in the Medical Society's building, October 29. Dr. Ralph Herz of Cleveland, Ohio, guest speaker, presented a paper on "Herniation of Subfascial Fat as a Cause of Low Back Pain."

At the third annual meeting of the **Association of Honorary Consultants to the Army Medical Library,** October 4 and 5, held at the Hotel Statler, plans were discussed for the new building. Dr. John F. Fulton of Yale University School of Medicine, President of the Association, addressed the opening session. At the dinner meeting, October 4, Major General Norman T. Kirk, Surgeon General of the Army, was one of the speakers. Among the topics presented during the two-day session was the advisability of a permanent fund for the work of the Honorary Consultants by Dr. Morris Fishbein, Editor of the *Journal of the American Medical Association.*

The appointment of 13 new members to the faculty of **Georgetown University School of Medicine** has been announced by the Very Rev. Lawrence C. Gorman, S.J., President of the University. They are:

Dr. Charles F. Geschickter, Professor of Pathology and Director of the Department of Pathology; Dr. Walter C. Hess, Professor of Physiological Chemistry and Director of the Department of Physiological Chemistry; Dr. Darrell C. Crain, Instructor in Clinical Medicine; Dr. Ellis April, Instructor in

Clinical Medicine; Dr. Lloyd G. Lewis, Associate Professor of Urology; Dr. Charles P. Howze, Professor of Clinical Urology; Dr. John P. Gallagher, Assistant in Neurosurgery; Dr. Philip Burka, Instructor in Surgery; Dr. J. Parran Jarboe, Instructor in Surgery; Dr. William Russell Moses, Instructor in Surgery; Dr. John Murphy, Instructor in Surgery; and Dr. James H. Scully, Instructor in Surgery.

The George Washington University Alumni Association, at a luncheon held at the Mayflower Hotel, October 5, celebrated the 125th anniversary of the founding of the University. At the luncheon 16 faculty members who had served for 25 years were honored. Each was introduced to the assembly and presented with a testimonial certificate. Those honored from the School of Medicine were Dr. Watson W. Eldridge, Associate in Medicine, Dr. Custis Lee Hall, Clinical Professor of Surgery, Dr. Roscoe W. Hall, Clinical Professor of Psychiatry, Dr. Jacob Kotz, Clinical Professor of Obstetrics and Gynecology, Dr. Paul S. Putzki, Clinical Professor of Surgery, Dr. Frederick A. Reuter, Professor of Urology, Dr. Joseph H. Roe, Professor of Biochemistry, and Dr. Herbert H. Schoenfeld, Associate Clinical Professor of Surgery.

Among those who spoke were Dr. Cloyd H. Marvin, President of the University, Dr. Chester W. Holmes, President of the Alumni Association, and Dean Elmer L. Kayser, Senior Professor in History.

Dr. Herbert P. Ramsey was elected **second Delegate to the American Medical Association** at a special business meeting of the Medical Society, October 23, and **Dr. Harry F. Dowling** was elected **Alternate Delegate,** their terms ending July 1, 1948.

Because of reapportionment of delegates at the recent meeting of the House of Delegates in San Francisco, the Society became entitled to an additional delegate. The new delegate will be seated at the next annual meeting of the House of Delegates in Atlantic City, in June, 1947.

It was suggested to the Society that the two delegates and their alternates be elected so that their terms will expire on alternate years. The Society's senior delegate is Dr. C. B. Conklin, whose term expires July 1, 1947.

Brigadier General Wallace H. Graham, M.C., A.U.S., personal physician to President Truman, was elected to Honorary Membership in the Medical Society of the District of Columbia, at the Society's meeting, October 23. In submitting the name of General Graham to the Society for election, the Chairman of the Executive Board quoted from a previous report: ". . . What makes him stand out from many of his contemporaries is his outstanding record as a medical officer in World War II. He recently received the Legion of Honor and the Croix de Guerre from the French Government for his services in Normandy. He was cited for personally caring for wounded French soldiers while serving as Chief of the Surgical Service of the 24th Evacuation Hospital.

"In the short time Colonel Graham has been in Washington he has shown a great interest in our Society, and, in consequence, has become well known to many of our members. He has attended our Society meetings and participated in the activities of many smaller medical organizations."

In a brilliant ceremony in the Academy of Medical Sciences at Habana, Cuba, on Thursday, October 3, **Dr. Hugh S. Cumming,** Director of the Pan American Sanitary Bureau and Surgeon General (retired) of the U. S. Public Health Service, was presented with the Gran Cruz de Finlay in recognition of his service to humanity. In the absence of the President of the Republic, the presentation was made by His Excellency, Doctor José R. Andreu, Minister of Health and Social Welfare, in the presence of many distinguished physicians and diplomats of the Western Hemisphere.

Dr. Cumming, accompanied by Mrs. Cumming, had gone to Habana to attend the meeting of the Directing Council of the Pan American Sanitary Bureau, which had been called by him for October 1–10, 1946, to discuss, among other things, the question of the proposed Constitution of the World Health Organization recently adopted at a conference in New York called by the United Nations. The Directing Council, which consists of official representatives from a majority of the governments of Latin America, unanimously adopted a resolution to advise their governments not to ratify the proposed Constitution unless there be included in it a reservation protecting and maintaining the integrity of the Pan American Sanitary Bureau, and recommended postponing action until the whole subject can be thoroughly discussed at the Twelfth Pan American Sanitary Conference to be held in Caracas, Venezuela, in January.

Arthur B. Solon, Superintendent of **Suburban Hospital,** Bethesda, announces the following additional appointments to the attending staff:

Dr. Walter Atkinson, surgeon; Drs. Walter Gerwig, John Norcross and George H. McLain, associate surgeons; Drs. William J. Tobin, Milton C. Cobey and Allen S. Lloyd, orthopedic surgeons; Dr. Norvell Belt, urologist; Dr. Roland White, otolaryngologist; Dr. Hugh Fulcher, neurosurgeon, and Dr. Reginald Mitchell, associate pediatrician.

Dr. Leo B. Gaffney was promoted to attending surgeon; Dr. Julius J. Radice to attending orthopedic surgeon; and Dr. Charles W. Schutz to attending pediatrician.

Additional names of members of the Medical Society continue to appear on the programs of **Professional Staff Proceedings of Walter Reed General Hospital.** They are Drs. Carl Berg, Aubrey O. Hampton, John Minor, E. Conner Moss and Seymour Rosenberg.

Dr. George F. Lull, Secretary and General Manager of the American Medical Association, and **Dr. Joseph S. Lawrence,** Director of the Council on Medical Service and Public Relations of the AMA, were guest speakers at the recent annual meeting of the Medical Society of Virginia, which was held at Virginia Beach, October 14–16, 1946.

Dr. Brian W. Blades, Director of Thoracic Surgery for the Veterans Administration, and Professor of Surgery at George Washington University School of Medicine, was the guest speaker at the monthly staff meeting of Mount Alto Hospital, October 8. His subject was "Mediastinal Tumors."

Dr. Norvell Belt has been appointed physician-in-charge of the Venereal-Disease Rapid Treatment Center at Gallinger Hospital operated by the Health Department. He will also be in charge of the second rapid treatment center to open later at the Toner School, 24th and F Streets, N. W. Dr. Belt is senior attending urologist at Garfield and Suburban Hospitals and Chairman of the Society's Subcommittee on Venereal Disease.

Dr. Winfred Overholser, Superintendent of St. Elizabeths Hospital, addressed members of the Washington Civitan Club, October 1, at the Mayflower Hotel. He described the functions of the institution and spoke in favor of voluntary admissions to the Hospital.

Dr. Sterling V. Mead, Associate Member of the Medical Society, was installed as President of the American Dental Association at its 87th Annual Convention held recently in Miami, Fla.

Dr. Daniel L. Seckinger, Assistant Health Officer for the District of Columbia, addressed the Junior Board of Commerce at a luncheon at the Annapolis Hotel, October 10.

Theodore Wiprud, Secretary of the Medical Society, addressed members of the St. Elizabeths Hospital Medical Society, October 22. The subject of his talk was "Medical Economics—Then and Now."

Drs. Thomas A. Egan and Russell C. Payne, together with **Dr. Joseph F. Zelenka, Jr.,** who is a dentist, and **Tony Alderman,** dental technician, journeyed 15,000 miles by plane to the Pribilof Islands in Bering Sea above the Aleutian Chain, where they made chest X-rays, tuberculosis tests, extracted teeth and made dentures for the natives. This medical mission was sponsored by the Department of the Interior.

Three members of the Medical Society, **Drs. Harry H. Kerr, James F. Mitchell and George Tully Vaughan,** were included among the physicians invited to attend a three-day meeting at the Massachusetts General Hospital, Boston, October 14–16, commemorating the 100th anniversary of the use of ether anesthesia in surgery.

Surgeon General Thomas Parran of the United States Public Health Service was awarded a citation for service, September 28, at the 12th Annual Meeting of the American College of Hospital Administrators in Philadelphia.

Dr. Thomas J. Pekin has been appointed Chief Medical Officer at Veterans Administration Hospital

(Mount Alto) succeeding **Dr. Frank Bacon,** who resigned to enter private practice. Dr. Pekin, a graduate of Loyola University, has been a member of the medical staff of the Hospital since 1937. He was separated from the U. S. Army in February with the rank of Lieutenant Colonel. During his war service he spent a year in France as Chief of the Medical Service with the 195th General Hospital.

Dr. Lawrence E. Putnam has been appointed director of the outpatient dispensary at Emergency Hospital to fill the vacancy caused by the recent death of Dr. John J. Shugrue.

Dr. William F. Burdick spoke in the interest of the Children's Hospital Building Fund at the meeting of the D. C. Pharmaceutical Association, September 19.

Dr. J. Thomas Schnebly addressed the D. C. Society for the Prevention of Blindness, October 4, 1946.

The Society's Office would greatly appreciate any copies of the July 1946 MEDICAL ANNALS that members may have on hand and do not plan to retain for binding. The office supply of other issues of the ANNALS has been greatly deleted by requests for back numbers, particularly January, February, May, June and July, 1946, and January, March, April, May, June and July for 1945. Members are urged to return copies of any of these issues to the Society if they have no further use for them.

BOOK REVIEW

Diseases of the Breast, 2d ed. CHARLES F. GESCHICKTER, M.A., M.D., Lt. Comdr., Medical Corps, U. S. Naval Reserve; Director of The Francis P. Garvan Cancer Research Laboratory; Pathologist, St. Agnes Hospital, Baltimore; with a Special Section on Treatment in collaboration with Murray M. Copeland, A.B., M.D., F.A.C.S., Instructor in Surgery, Johns Hopkins Medical School; Visiting Surgeon and Assistant Oncologist, University Hospital, University of Maryland Medical School; Visiting Oncologist, Baltimore City Hospitals. Price, $12.00. Pp. 826, with 593 illustrations. Philadelphia: Lippincott, 1945.

When the first edition of this volume appeared in 1943, it was accorded a warm reception by those to whom has fallen the responsibility for treating diseases of the breast. The second edition, which was actually written two years after the first, retains the orderly and exhaustive treatment which was so evident in the original volume. The primary addition to this newer work consists of an enlargement upon the discussions of tumor formation, a considerable number of original illustrations, an amplification of therapy for neoplastic disease, and much more complete and up-to-date bibliographies at the chapter ends.

One particularly refreshing feature of the author's view of the pathologic complex, which embodies graduated cystic disease of the breast extending into neoplasm, is the rational and scientific terminology which is employed. For instance, the term "adenosis" is used in lieu of "Schimmelbusch's Disease," and "adenocystic or microcystic disease" are given to the reader as possible, if less desirable, synonyms.

The chapter on endocrinology should be an excellent reference source for the general practitioner, surgeon and gynecologist. No major sin of omission is committed in this illuminating chapter.

The author's vast and personal knowledge of, and experience with, the experimental production of neoplastic and cystic disease of the breast lends authority to his conclusions on these subjects, and clarifies his evaluation of the entire problem. The section on treatment, which was written in collaboration with Dr. Murray M. Copeland, utilizes to the fullest the combined experience of the oncology services of four of Baltimore's most famous hospitals. This section should be carefully perused by students and practitioners alike—indeed, by anyone who at any time has occasion to diagnose or treat diseases of the breast.

In conclusion, it may be safely stated that this work is almost unique, that it is well written, beautifully presented, and that it should serve amply as both a text and as an authoritative reference source on diseases of the breast.

JACOB J. WEINSTEIN, M.D.

EDWARD J. GUNNING, M.D.

(1871–1946)

Dr. Edward J. Gunning, an Active Member of the Medical Society of the District of Columbia, died September 24, 1946, in St. Petersburg, Florida, where he had resided for the past few years.

Dr. Gunning was born in Pittsburgh, Penna., August 9, 1871. Receiving his degree in medicine from George Washington University in 1905, he began active practice in the District of Columbia the same year, which practice extended over a period of almost 40 years.

He was a Fellow of the American Medical Association. He became a member of the Medical Association of the District of Columbia in 1907.

A son, T. Hobbs Gunning, who lives at 1313 Spruce Street, Philadelphia, Penna., survives him. Dr. Gunning's last address in Washington was 1616 16th Street, N. W.

WILLIAM JOSHUA GROOT THOMAS, M.D.

(1875–1946)

Dr. William J. G. Thomas, an Associate Member of the Medical Society of the District of Columbia, died September 22, 1946, at Garfield Hospital following a long illness.

Dr. Thomas, a native Washingtonian, was born September 18, 1875. He graduated in medicine from George Washington University in 1908 and began practicing medicine in the District of Columbia in 1910. During World War I he served as First Lieutenant in the Medical Corps. He had last maintained his office at 1830 K Street, N. W.

Dr. Thomas became affiliated with the District Medical Society as an Active member in 1911, but transferred his membership to Associate in 1940 because he was no longer engaged in active practice. He was a member of the American Medical Association and the George Washington University Medical Society.

Following his retirement he lived for several years in St. Petersburg, Florida. Upon his return to Washington in March of this year he resided at 4420 Yuma Street, N. W.

Surviving are his wife, Mrs. Regina C. Thomas, of St. Petersburg, Florida, and four children by his first wife, Mrs. Lina P. Thomas, who died in 1939. They are a son, Dr. W. Raymond Thomas, an Active member of the Society, and three daughters, Mrs. Walter B. Long, Mrs. Thomas Alden Bradford, and Mrs. T. Girard Lee, all of Washington.

Removal of Hair—Robinson

(*Continued from page 536*)

are scattered over wide areas on the face and since the average number of treatments are 1 or 2 a week.

The amount of scarring in this method is far less than with negative galvanism. If proper precautions are taken not to pierce the follicle, not to get the point of the needle too close to the skin surface, and not to work on hairs which are too close together, the scarring is to all intents and purposes absent. I do not believe that there is any real difference in the regrowth of hair with either method, if the technic is controlled. The regrowth of hair is probably due to the variations in the position of the hair and its anatomic peculiarities which the operator can neither see nor feel. If the follicle has an angle, the hair will be destroyed above the papilla and will of course regrow. This regrowth, which amounts roughly to 10 to 20 per cent, is offset by the rapidity of the method.

Although treatment of hypertrichosis is a tedious process by any method, there is a vast difference in having to hold a fine needle in place for 30 seconds to 2 minutes, and holding that needle in place for only a few seconds. When one has to hold the needle still for a relatively long time, it is much easier to pierce the follicle or to ease it away from the papilla. Whenever this happens there is a greater possibility of scarring.

Note: Photomicrographs and biopsies by Army Institute of Pathology; other photographs by the Liebel-Flarsheim Company. All are reduced from the originals.

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Liver Disease--Wells

(*Continued from page 545*)

In the presence of ascites, two methods of relief are present: (1) paracentesis, and (2) mercurial diuresis. Very few patients live longer than 6 to 12 months after the second paracentesis. I personally prefer to prepare the patient with ammonium chloride and to use mercupurin diuresis if it proves effective. I have one case of a year's standing, and the patient is at work following 1 abdominal paracentesis and the periodic reduction of his ascitic fluid with mercupurin. I have another who is working, and whose ascites has been controlled for $1\frac{1}{2}$ years with mercupurin following 2 abdominal paracenteses within the 6 months preceding the institution of the above régime. It has been my experience that 1 c.c. of mercupurin gives as good a diuresis, if not better, than 2 c.c. and that the side-effects of mercupurin administration are lessened by giving it slowly in 50 c.c. of 50 per cent glucose.

SUMMARY

The embryology and physiology of the liver have been briefly reviewed. Interpretation of the various tests for liver function have been outlined. The etiology, symptomatology and the changing concepts in the therapy of portal cirrhosis have been discussed. The stress should be on early diagnosis, adequate and prolonged treatment, and these demand utmost patience, perseverance and optimism on the part of both the doctor and the patient.

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Safest Investment in World

(*Continued from page 563*)

sale of savings bonds as the best means of protecting the value of the dollars we have already saved. The money we have saved the hard way during the times when a "dollar was a dollar" loses its value in direct ratio to the increase in the cost of living. Our best way to help check this rise and to help halt the deflation of our saved dollars is through savings bonds.

We don't mean that you are expected to buttonhole your associates and patients and flash a savings bond application blank. W. J. Waller, Chairman of the District Savings Bonds Division, is not asking for a door-to-door canvass. He is asking merely that we as individuals talk the virtue of United States Savings Bonds, the growing need for greater investment now in such bonds, and the excellent rate of interest they pay—$4 for every $3 when held to maturity.

And, of course, most important of all, we are being asked to buy United States Savings Bonds . . . to the very limit, not only because every bond we buy is extra protection to the savings we now hold, but because United States Savings Bonds continue to be the safest investment in the world.

W. Calhoun Stirling, M.D.
Chairman, Medical Section,
District Savings Bond Division

MEDICAL ANNALS

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ATOMIC ENERGY AND YOUR FUTURE HEALTH*

GEORGE M. LYON, M.D.

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I. Some Psychologic Problems Associated with the Atomic Bomb

WITHIN the past fortnight General Eisenhower stated to the press that the atomic bomb was the most destructive weapon yet devised. The observations in Japan and at Bikini bear unmistakable evidence of this fact.

On every hand we see evidences of the strong psychologic impact this knowledge has had on our people. Inherent in the bomb and in its wartime use there are intrinsic characteristics which provide basis for tremendous psychologic effect. Chief among these characteristics are:

1. It is the most destructive weapon.
2. It can be delivered by airborne attack at great distances.
3. It may produce serious radioactive contamination, particularly when detonated under water.
4. It may be employed in strategic bombing involving civilians in areas well behind a battle front.

To these must be added those features which exploit fear of the unknown, of the unseen, and, in a certain sense, of the supernatural.

Although we have not been subjected to atomic bomb attack, we ourselves have been exposed to some of the psychologic influences to which this weapon has given rise. Indeed, they have made significant inroads on most of our psychobiologic make-ups. There is a new stress for each of us to meet. It is necessary that we meet it as sensibly as we can, both as individuals and as a people.

Because of the importance of this aspect of the atomic bomb, and because of the great and vital need for each of us maintaining ourselves in a state of mind which will permit us to think clearly and exercise good judgment, I want to discuss in some detail the many aspects of this problem which must be considered in relation to our future health, if not indeed to our future existence. The situation is one which calls for positive action on your part and mine if we are to succeed. Although the problems of the atomic bomb are important, they are only a part of a larger complex.

May I take a mythical Mr. John Q. Citizen as representing the average American of today and draw a rough, but, I believe, applicable simile? May I further suggest that this man presents symptoms suggestive of a mild "exhaustive psychosis" and that his symptoms consist primarily of restlessness, difficulty in orientating himself, and difficulty in adjusting to his environment. He tries to be his usual self but finds that he cannot shake off a persistent state of mild confusion often mixed with outright anxiety. He knows something is wrong, but he just cannot put his finger on it and "snap out of it."

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Parenthetically, let me state here that if we are honest with ourselves, we will be frank in admitting that each and every one of us suffers somewhat this same set of feelings, although in varying degrees. Of course, this state is not entirely due to the introduction of the atomic bomb, although the bomb's psychic shock has contributed.

Let us now review the facts which may have had some bearing upon this man. Let us see to what environmental stresses he may have been subjected, over and above those of more ordinary times.

On August 6, 1945, the President of the United States announced to the world that less than 16 hours before an atomic bomb had been employed at Hiroshima. Thus was the birth of a new era in human relationships and responsibilities disclosed. This announcement was followed by that of the Secretary of War, in which was divulged for the first time the fact that a gigantic organization known as the Manhattan Engineering District had existed for 3 years prior to that time. This was the official organization responsible for the development and production of the atomic bomb. The first man-made atomic bomb had been detonated in an isolated desert in New Mexico, scarcely 3 weeks before the Hiroshima bomb episode, while President Truman was attending the Potsdam Conference. Hardly had the word been announced regarding Hiroshima than word came of the use of another atomic bomb at Nagasaki. This was followed shortly after by the complete collapse and surrender of Japan.

These announcements came with such rapidity and they were laden with such terrifying implications, that it was impossible for anyone to have a realistic picture of the history which had been made, and of the awful impact which these events would make on the future of the world.

To the physician, certain by-products of this new era were immediately discernible. Some were evidenced in the behavior of the individual. Others were observed in widely varied patterns of mass or group psychology. To a nation and a world already tired from war and desirous of peace it was a difficult time to be confronted with matters of such stupendous implications as those born with the knowledge that nuclear fission could be employed in a powerful and usable weapon of war. That most of our nation, and of the world for that matter, was in such a state of fatigue and bewilderment as a direct result of several years of the most extensive and intensive form of warfare yet known to man, was in itself reasonable cause for much in the way of uncertainty, if not indeed insecurity, in the minds of most individuals. This is important to bear in mind as we attempt to study the effects of the introduction of the atomic bomb on the people of a nation, and a world, so fraught with fatigue, confusion, and uncertainties. These stresses have produced serious functional as well as emotional reactions. Many individuals have been forced to seek medical attention because of them. Physicians are observing daily evidences of the human reactions I refer to here. The student of human behavior finds manifestations of a similar background in the news of the day as reported in the press. These reactions are to be seen in the behavior of the man on the street, in the homes of most of us, in our universities, in industrial relations, and in much of our political planning and doing. That such phenomena of human behavior occur following war has long been a matter of historic record. That the period immediately after a war may be quite as difficult for the individual or for the nation as is the period of war, is also well recognized. To this, the conquering nations are no exception. It is probable that the greater and the more intense the all-out effort of a nation, and the more protracted the duration of hostilities, the greater the difficulties of readjustment which the nation must undergo. It is further quite probable that much of the present-day difficulty arises from the fact that technology, quite aside from the atomic bomb, played such an important role in this last war. Important in this respect were the influences of the long-range bomber, the searching eyes of radar, the long ears of sonar, the introduction of the bazooka, the unmanned V-1, a diversity of rocket weapons including the V-2, and guided missiles of yet undescribed characteristics, all of which had been employed in this war prior to the use of the atomic bomb. In most of these there is to the average person something of an awesome or supernatural nature. The development and use of such weapons, and the tempo with which many of them were employed both against combatant personnel and against civilians in more removed areas, have provided reasonable basis for most of us having some feeling of uncertainty. The fact that destructive war can be abruptly and unexpectedly brought to bear on the forces of the United States was impressed on most of us when on December 7, 1941, the Japanese attacked Pearl Harbor. Since that time many new and increasingly more complicated weapons have been developed, and have become available. Truly, the means of waging war in the future are staggering to contemplate. This would be true even if the atomic bomb had not been developed. The sane and informed person cannot help but have some feeling of uncertainty. I use the word uncertainty because I feel that the term insecurity implies an element of weakness, and perhaps helplessness, and this we must avoid.

I have dealt in considerable detail on certain facts which are, I believe, essential for us as physicians to realize in our attempts to analyze the influence which the use of the atomic bomb has had on the emotional and psychologic behavior of our people, and on our patients. Certainly the introduction of atomic warfare came at a time when we were tired, confused, and generally in a poor state of mental health both as individuals and as a people.

When the initial impact of the announcement of the use of the atomic bomb at Hiroshima occurred, it fell on a nation eager for peace. The first and most widespread reaction, among the most of our people, was one of elation, based in part on the fact that we had a powerful new weapon, and in part on the fact that as a nation we were sick and tired of war and this new weapon would probably make for an early termination of hostilities, inasmuch as it appeared unlikely that any nation could long stand up against such devastating and demoralizing weapons as these bombs had proven to be. To a relatively few at this time did the awful implications appear in their real light. These were, on the one hand, those military leaders who immediately recognized it as the most destructive weapon of all time and who appreciated full well what a serious threat it could be to our national existence were it to be employed against us in time of war, and, on the other hand, the scientists who, appreciating its terrible effects, sought early to enjoin others in an attempt to prevent atomic warfare through international control of the production of fissionable material and bombs. Since then, conflicting statements from persons of apparently reliable authority have tended to further aggravate and confuse the issues involved.

To add further to the difficulties in the way of clear thinking, not long after the termination of hostilities in the Pacific area it was announced that remarkable and terrifying advances had been made by the United States and other warring nations in the development and tactical employment of weapons of chemical warfare. About this same time the press carried official releases telling of accomplishments in the defensive aspects of biologic warfare. Prior to this time few people outside of key military personnel, and some civilian scientists, were aware of the fact that throughout the last war we, and our allies, were continuously faced with the threat of employment of chemicals by the Germans and of biologic warfare by the Japanese and that tremendous efforts had been expended on our part in the development of defensive counter measures.

There are other contributory aspects, such as the newsworthiness of so much of this information when it was announced, the graphic and at times emotional descriptions of detail, the difficulty of disseminating factual information relative to these special weapons and their effects, the relationship to military secrecy, and the inherent difficulty of lay evaluation of these matters.

So far I have dealt only with those stresses arising directly from the weapons employed in war. I need only mention the sociologic and political problems so well known to us all, and which are always aggravated during war and in its aftermath. They, too, are important and are in great measure increased by the disturbing influences I have described at length.

The over-all picture from the standpoint of environmental stresses is very complex and anything else but attractive.

Now let us turn our attention to our patient. We recognize the effects of fatigue and the persistence of a wide range of environmental stresses, many of which may never be satisfactorily removed. We further recognize the confused mental state the patient presents, and we appreciate that because of certain unavoidable circumstances, including his lack of information, there is a reasonable basis for a lack of orientation and that we may have some difficulty developing his insight.

What now can be done with our patient so far as the problems related to the atomic bomb are concerned? The first thing we can do is to provide him with a factual, honest picture of just what the atomic bomb can do, and what it cannot do. This means giving him accurate information, and an honest and sincere interpretation of its potentialities and its limitations to the best of our ability. His insight can be built up only on truth.

Now let me go to some of the information which we as physicians may need to know if we are to treat the patient properly. This information is available. You may be somewhat surprised to learn that in the early planning of Operation Crossroads, and consistently throughout the operation and since, Admiral Blandy, the Task Force Commander, has insisted upon two things:

1. That we gain all the information possible as to the effects of the bomb when employed against target vessels, and

2. That an honest and factual portrayal of this information be given to the press, radio and other media in order that they might convey it to the public with as much accuracy and promptness as possible within the limitations set forth by military security.

So much in the way of wild, fantastic tales had gone about the country, and frequently had so transcended the bounds of reality, that we have faced a serious problem in this respect. Fantastic exaggerations of fact were, by loose, irresponsible tongues, said to come from those in authority, when in truth the truly responsible authorities were actively doing their very best to portray facts as they had been observed and were trying to the very best of their ability to prevent the initiation and circulation of such absurd statements. Having personally observed 3 of the 5 atomic bomb detonations, I am convinced that the facts as presented officially through the office of General Groves, and by his responsible representatives, have been true and free from exaggeration or distortion. The same obtains in regard to the information provided through the office of the Commander, Joint Task Force 1. I emphasize this because the only sources of accurate information have been the official releases by Manhattan District or Joint Task Force 1, or which have been prepared by other activities and cleared for publication through Manhattan District or Joint Task Force 1. The report of the United States Strategic Bombing Survey published June 30, 1946, under the title "The Effects of Atomic Bombs on Hiroshima and Nagasaki," portrays with accuracy the conditions observed. There are, therefore, reliable, authentic official sources from which suitable information can be obtained and which can serve as a reliable base upon which an individual can build his "insight." Valuable information has been added to this important source through the conduct of Operation Crossroads. We now do have suitable information upon which to build a factual concept of the potentialities and the limitations of this new weapon. Furthermore, facts essential to our practical understanding have not had to be withheld due to military secrecy. A summary of some of the important facts are:

1. Atomic warfare is a distinct possibility.
2. In time, other nations may be able to develop atomic bombs and use them against us.
3. We must be prepared defensively to the very best of our ability.
4. We must be alert to the terrible potentialities of an atomic war, and to the fact that even without the atomic weapon future wars will be terrible because of other comparably advanced developments in the technologic aspects of weapons and warfare.
5. The atomic weapon is the most destructive weapon yet devised, and it appears to have the most extensive influence of any weapon as far as the psychologic effects are concerned.
6. When the atomic bomb is burst in the air it will produce effects similar to those observed at Hiroshima and Nagasaki.
7. When the atomic bomb is burst under water, it is, as Admiral Blandy announced to the press, a form of poison warfare.
8. Much is now known as to the measures which may be taken in regard to overcoming many of the handicaps imposed by such attacks.
9. Much has already been learned which will be of value in the treatment of many of those who might be injured by such attacks.
10. The only completely effective protection against the atomic bomb explosion is to be a safe distance away from it.
11. The photographs liberally released to the press and the movies of the explosions speak eloquently of the magnitude of the atomic bomb explosion.
12. That it is possible to conduct many operations with safety in the immediate vicinity of the atomic bomb blast subsequent thereto was proven in Operation Crossroads and as has been described in the press.
13. That the military services will train personnel prepared to cope with the problems of radiologic safety, and that such training activities have been initiated under the auspices of Joint Task Force 1, in which the lessons learned at Bikini are being disseminated to all military services.

Now with these facts in mind, and recognizing that this is the most destructive weapon ever devised, and that no other weapon or group of weapons has ever had such a profound psychologic effect, let us encourage our patient to take an active interest in the welfare of himself, his family, and his nation, concentrate on maintaining a common-sense viewpoint with regard to the new weapon and other destructive aspects of war, and work toward such means as will prevent any wars in the future, and appreciate at the same time that it is necessary to keep our own nation defensively strong so that if another insane nation runs amuck, as did the Germans this last time, we will not be in a position of vulnerable unpreparedness.

My simile may have seemed far-fetched. The problem is real. Each of us is concerned. The atomic bomb is only an important contributing factor so far as our over-all dilemma is concerned at the moment. However, in an atomic era we can survive only if we face reality, recognize the dangers of atomic warfare, and as individuals think intelligently and act wisely in a positive manner.

II. RADIOLOGIC SAFETY AND BENEFITS TO BE DERIVED FROM OPERATION CROSSROADS

As Safety Officer on the Staff of Commander, Joint Task Force 1, I was concerned with the safety of over 40,000 individuals within the Task Force. Admiral Blandy directed that elaborate precautions be taken to insure the safety of all personnel involved in the operation.

We planned and carried out a very strict safety program, so strict indeed that we were criticized on many occasions for it. However, we were able to conduct the two tests without any injurious effects having been sustained by anyone either directly as a result of the explosion of the atomic bombs or indirectly as a consequence of the radioactive contaminations resulting therefrom.

Facts gained through Operation Crossroads have provided us with information which is essential to our collective welfare today. We are now in a position to more accurately evaluate the effects of an atomic explosion. We have been able not only to study the phenomena of the explosion, and to observe their effects on target vessels, but we have had actual experience as well in coping with the dangers which remain after the bomb has exploded. From any residual dangers which may be encountered in the vicinity of the explosion, whether the bomb is burst in the air, on the surface, or under the water, we have knowledge of the nature and magnitude of the hazard and we have successfully applied means of detection and avoidance which permit us to do much with safety which previously had been thought impossible. The same principles of safety operation could be employed were the bomb exploded on land surfaces. Much of importance which was truly unknown last spring is well known to our safety officers today. That we were so successful in safely protecting the personnel of the Task Force should offer a great measure of comfort to those who have exaggerated ideas as to the supercolossal aspects of the weapon. One bomb will not blow up the world, nor will one bomb contaminate an entire country. It will produce extensive damage, however, and under comparable circumstances the terrifying effects produced at Hiroshima and at Nagasaki can be reproduced. We should think of atomic bombs in terms of the destruction produced in these two cities, and not as many have felt, capable of wiping out or poisoning an entire state.

III. SAFETY IN RELATION TO OCCUPATIONAL HAZARDS

The occupational hazards associated with the production of fissionable material for the preparation of atomic bombs are essentially the same as those for the production of fissionable material for the pile which may create fuel energy in the future. Some of these processes of production are accompanied by hazards which are potentially serious. In the Manhattan Engineering District safety procedures were worked out under the direction of Colonel S. L. Warren, M.C., A.U.S., in such a manner that a most remarkable safety record was established, and the District received the outstanding safety award of the Nation during the years 1943–1945. The hazards were of two kinds in general: (a) those associated with corrosive acid fumes of great aggressiveness, and (b) those associated with external radiation or with poisoning or injuring from radioactive materials.

For those working near an operating pile, elaborate engineering and construction provided great safety. The development of an able corps of "health" physicists was an important aspect of safety. The story is one of broad and successful accomplishment in the field of safety operations. Much of it was due to engineering features, but some processes required much greater potential exposures than others. In a plant employing 100 personnel in what was potentially one of the most dangerous processes, not a single man lost an hour's work due to a plant-incurred injury during the 14 months it was in operation. When atomic energy is harnessed for peacetime purposes, the experiences and methods of protecting personnel which were so successfully developed during the production of fissionable material for war purposes will be available as a valuable contribution of this gigantic war effort.

IV. The Benefits of a New Era in Biologic Research

For the Secretary of War's Interim Committee on Atomic Energy, a panel of scientists, including Drs. A. H. Compton, E. Fermi, E. O. Lawrence and J. R. Oppenheimer, consulted with an additional group of scientists and specialists and then prepared for the Interim Committee an unpublished report on the beneficial possibilities which might accrue from atomic energy. Two great fields for beneficial use were discussed: (a) "The Development of Atomic Energy as a Source of Power" and (b) "The Application of Radiations and Radioactivities to the Growth of the Sciences, and the Practical Arts."

The report states, "It is probable that the exploitation of atomic energy as a tool for research will outweigh the benefits to be derived from the availability of a new source of power."

The same report discusses the opportunities which have been opened in the field of research as a result of the plentiful supply of radioactive substances which will be available as by-products of the manufacture of fissionable materials, a circumstance which may have as much meaning to scientific progress of the future as has the ready availability of the microscope today.

Because of its important bearing on our future health, I quote from this same unpublished report: "It should be understood that work specifically focused on atomic power need not and should not interfere with making available to biology, medicine, chemistry and physics the radiations and activities characteristic of this field. . . . We should not be astonished if the greatest benefit of this program were in fact to be in therapy for some of the neoplastic diseases, such as cancer, or in the increased understanding of biological systems or of the realities of the physical world which will in turn open up new fields of human endeavor."

I would like to return to another phase of this same report: "The unique preoccupation of the war years in the use of atomic energy has retarded our understanding of other applications." In view of this fact, it is essential that there be effected such control of atomic energy as may be required to safeguard to humanity the benefits which may be derived by pursuing in this area of research an intensive and constructive program which will employ this new and valuable tool to the very best advantage.

To speculate at this time just how new technics of employing radioactive isotopes in so-called tracer studies may be employed is beyond the scope of this discussion. The study of chemical and biologic processes within the living body of plant or man will constitute one of the most important fields of application. At first this will follow patterns which were being developed prior to the war. The availability of a greater number of such radioactive isotopes, and these in larger amounts and at less expense, will be one of the early beneficial contributions of the Manhattan Engineering District. The study of such processes will bring to light information not presently known and probably not obtainable by conventional technics of chemistry or physics. The technics of tracer study are still difficult of application in many respects. The inviting opportunities which lie in their use and in a readier supply of such tracer materials will attract many young scientists into this field, and undreamed of benefits may come from this new impetus to scientific endeavor. By most of the older scientists I have talked to, it is felt that the earliest positive contributions will come in the form of information gained from a clearer understanding of the biochemical processes within the body including those of metabolism, of the endocrine glands, and possibly even immunology.

In the field of experimental therapeusis it will be possible to identify the distribution of specific therapeutic agents within individual organs. It will also be possible to study their behavior in situ in a manner not now possible.

One is tempted to speculate on the possibilities of tracing certain toxoids or other immunologic agents, as well as the less complicated chemicals within the body. Various radioactive isotopes have already given great promise in the study of specific selectivity of various organs for a particular chemical. It seems likely that by this means there will be before long fairly common methods of checking the appearance of a particular therapeutic agent in an individual organ. There may be an especially profitable application of this new tool when the amount of the chemical to be identified is so small that it would be impossible by the usual technics of chemical analysis, and when the radioactive isotope is present mixed with its non-radioactive counterpart. As many of you know, it is possible to identify radioactive sulphur in an organ containing both this and ordinary sulphur. This method was employed during the war in studying the transportation of mustard gas within the body and in attempted methods of treating the injuries produced by this compound. Radiosulphur has been employed in the synthesis of vitamin B_1 (thiamine) and the movement of this vitamin within the body has been traced by this means.

An outstanding virtue of tracer technics in studying biologic processes lies in the fact that it is possible to differentiate between atoms and molecules of the material administered and those already present in the tissues of the plant or animal when this would be impossible by chemical procedures. In some instances it is possible to identify radioactive isotopes in concentrations one millionth of that possible by chemical means. Some materials which would be highly toxic in the concentrations permitting identification by chemical means can be studied with safety when tracer technics are employed because the concentrations required are so minute they would not be injurious to the cells.

The fact that the radioactive isotope of a stable element differs only in its property of radioactivity and has identical chemical and physiologic properties makes it possible to conduct such tracer studies. This is in some instances limited in its applicability because of the fact that the radioactivity of the tracer isotope may produce cellular injury due to its radioactivity. Usually this is not a problem because the amounts of material required are usually so small as to present no danger.

Tracer studies have been carried on in at least three different ways:

1. The material containing the radioactive tracer can be given by mouth or otherwise. The tissues to be studied may then be removed and examined directly by a variety of methods.

2. It is also possible to measure in situ the radioactivity of materials so administered by placing a Geiger tube over that part or organ to be studied, and then measuring the radiations emitted. This has been done in studying the deposition of radioactive iodine in the thyroid.

3. An impressive method is the making of radioautographs. The photographic action of the radioactivity is utilized. The radioactive material is administered. Tissues are removed, thinly sectioned, and then placed in contact with suitable photographic film, exposed in the dark, developed and studied under a microscope. Such studies frequently establish close correlation between the deposition of the radioactive material and histologic structure of the tissue. We had occasion to employ this technic in a modified form at Bikini, in studying the concentration of radioactive material, in the algae of the lagoon, and in the fish. By impressing a spray of algae on such a film and leaving it in a

dark room for 24 hours, a method employed in research laboratories, we were able to demonstrate the concentration of radioactive materials in these plant forms. Similarly, with the fish we were able to demonstrate the algae in the stomachs of the small fish and subsequently even the smaller fish within the stomachs of the larger fish. It was spectacular and a valuable aid in our studies.

In the field of pure research, the tools now at hand, enhanced by the impending availability of more and newer radioactive isotopes, promise a very bright and fruitful future if properly protected and energetically pursued.

In the field of therapy it is likely that a similarly bright future may be ahead. Here we may have an entirely new tool to use in the treatment of specific organs or of particular conditions such as neoplastic diseases. The specific selectivity of a particular tissue or the specific deposition of a particular radioactive isotope may eventually be employed to advantage in the local irradiation of tissues in which it is desirable to produce certain inhibiting changes, if not actual destruction. Radioactive phosphorus has been employed clinically in the treatment of leukemia and radioactive iodine in the treatment of neoplasm of the thyroid. Neither has, however, been entirely satisfactory, and a word of caution should be sounded in regard to premature enthusiasms, since as yet much basic work needs to be done before we can have successful application of this form of therapy.

I have dwelt at some length on this rather newer tool of research, because it is generally believed that it is in connection with the extended application of this tool that we may hope to see the tangible fruits and benefits arising from one of the probably most important contributions of our new atomic era. The romance which undoubtedly lies ahead for those fortunate investigators who enter this field has probably never been equalled in the past, certainly not in the field of biologic research.

TUMORS OF LYMPHOID TISSUES

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CONFUSION is a word which aptly designates the classification of tumors of lymphoid tissue. The etiology, cytology and interrelationships are interpreted differently by every author. An attempt to devise a classification which includes names and subdivisions indicated by a variety of authors has been made. An adequate listing of lymphoid tumors should contain not only those which are conceded by all as true neoplasms but certain others which have been considered as granulomas but are known to bear certain relationships to the "true" tumors.

Classification

1. Tumor-like conditions
    - A. Lymphocytes
        - a. lymphocytic lymphoma } Lymphosarcoma
        - b. lymphoblastic lymphoma }
        - c. giant follicular lymphoma
    - B. Reticulum cell
        - a. stem cell lymphoma } Reticulum-cell sarcoma
        - b. clasmatocytic lymphoma }
        - c. Hodgkin's sarcoma
        - d. myeloid leukemia
    - C. Endothelial cell
        - a. endothelioma (syncytial reticulosarcoma) local or diffuse
2. Granulomatous-like conditions
    - A. Hodgkin's granuloma

This classification was made after a review of those classifications presented by the National Registry of Lymphoid Tumors, Ewing, Gall and Mallory, Callender, Robb-Smith, and others.[1-25] It was considered necessary to adopt such a classification in order to consolidate the different views.

The cellular structure and origin of the lymphoid tissue is still a matter of dispute. A working hypothesis is that outlined by Wiseman[1] in which 4 phases of cellular maturation are proposed. The cell of origin is believed to be the fixed reticulum cell. This gives rise to a primitive blood cell from which the lymphoblast arises. From the lymphoblast the large lymphocyte develops, and finally the small lymphocyte appears. Each of these cells may proliferate and reproduce cells of its own kind as well as maturing and giving rise to the next cellular phase. The first 3 maturation levels develop by mitotic division; the last level, which forms the small lymphocyte, follows an amitotic division. If maturation arrest occurs at any level the arrested cells may reproduce themselves to such an extent as to displace the rest of the lymphoid tissue and show the histology of a neoplasm. The cell potency of reticulum cells is not generally confirmed, but it is more logical to concede the lymphocyte formation from this cell until better evidence is presented proving the contrary to be true. The primitive reticulum cell, or stem cell, resembles the hemocytoblast of bone marrow, and it is not inconceivable that the two are the same cell but in different locations. It is suggested in the literature that the different conditions present in lymphoid tissue influence the hemocytoblast to form lymphocytes instead of granulocytes. From this thesis it is postulated that during myeloid leukemia the lymphoid tissue hemocytoblast may form granulocytes; still others, however, do not accept this theory and feel that the myelogenous cells in the lymphoid tissue are merely a form of tumor or neoplastic infiltration. The other cell of these tissues which may exhibit neoplastic or hyperplastic proliferation is the endothelial cell of the sinusoidal spaces.

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Miller and Turner[2] have isolated 2 factors which they believe influence hematopoiesis in lymphoid and marrow tissues. These factors were obtained and concentrated from the urines of patients having diseases involving blood-forming tissues. In myeloid leukemia a non-carbinol fraction (an organic compound without a hydroxyl group) was obtained from the urine which on experimental administration to animals caused proliferation of marrow cells to such an extent that the original leukemic process was simulated. Likewise, in lymphatic leukemia a carbinol fraction (an organic compound with a hydroxyl group) was obtained which experimentally produced lymphoid tissue changes similar to those of the original process. The experimentally produced changes by administration of fractions from leukemic cases were always the changes of a chronic leukemia whether the factors were obtained from acute leukemic or chronic leukemic patients. It was interpreted that both of these factors, the carbinol and non-carbinol, are normally present in the body, and only when in excess do they appear in the urine. Postulating, these investigators suggest that when there is deficiency of both fractions an aplasia results, while if there is excess of one with a normal amount of the other a characteristic hyperplasia occurs which is chronic in nature; if there is excess of one with a corresponding diminution in the other an acute process or exacerbation is supposed to present itself. In Hodgkin's disease, monocytic leukemia and lymphosarcoma they were able to produce the histopathologic changes similar to the original process by experimental administration of the respective concentrated urine fractions. Also, they produced a Hodgkin's disease or monocytic leukemia tissue change by injection of equal quantities of both the carbinol and non-carbinol fraction. A lymphosarcomatous change occurred if the specific urine concentrate or the carbinol fraction was injected. From these studies it is fairly well evident that there are present in the body factors, similar to the erythropoietic factor, which stimulate lymphopoiesis and granulopoiesis, and that when some metabolic, infectious or neoplastic change occurs an excess of one or both of these elements results, some "spilling" into the urine.

The tumors of the lymphocytic series of cells are called lymphosarcoma and leukosarcoma if there is a concomitant lymphocytosis. Depending on the maturity of the cell composing a lymphosarcoma there are lymphoblastic and lymphocytic types. The two most immature lymphoid tumors are the stem-cell lymphoma and clasmatocytic lymphoma which together form the subdivisions of the reticulum-cell sarcoma. Hodgkin's sarcoma occupies an unusual position among these tumors because of its relationship with granuloma, but it is derived from the reticulum cell. If we suppose that the "hemocytoblast" of lymphoid tissue may under certain conditions give rise to myelogenous cells, myeloid leukemia is listed as a derivative of the reticulum cell; however, the future place of this neoplastic process depends on whether the reticulum cell of lymphoid tissue is found to be a totipotent cell or not. The giant follicular lymphoma was first considered a benign lymphoid hyperplasia, but because of its frequent development into lymphosarcoma it is now considered inherently malignant. The extensiveness of the neoplastic process involving the sinusoidal endothelial cell enables its subdivision into a local and diffuse type, which is further elaborated later.

Hodgkin's granuloma occupies an intermediary position, in that it is not histologically characteristic of a neoplasm but invariably terminates fatally and not uncommonly develops into a sarcomatous picture. Because of these characteristics it must be included in any discussion on lymphoid tumors.

Gross Pathologic Anatomy

Although the gross appearance of these tumors is similar, certain features tend to subdivide them into groups. Because of the necessity of differentiation from inflammatory hyperplasia of lymph nodes it is well to discuss the "reactive node" when considering lymphoid tumors. This "reactive" hyperplasia is grossly a discrete, firm, somewhat tender, at times reddened and hot, nodular enlargement. The capsule of the enlarged node is not thickened, but inflammation may cause some fusion of adjacent capsules. The nodes are usually movable and enlarged, sometimes markedly. On section there is an opaque, greyish-white, homogeneous cut-surface. Suppuration, but usually no necrosis, occurs if the infectious source is severe. The lymph nodes most commonly involved are those exposed to drainage from infected foci. Thus the cervical, axillary and inguinal nodes are not infrequently involved.

The giant follicular lymphoma presents enlarged, discrete, firm nodes. The capsule is usually not thickened, and there is no capsular invasion or fusion of adjacent glands. Therefore, the enlarged node is movable. On section there are distinct elevated nodular areas which are dispersed diffusely through the entire node. The tissue itself is greyish white and rough. The nodular areas on the cut-surface represent increased numbers of enlarged lymphoid follicles. Their diffuseness throughout both cortex and medulla differentiates these nodes from a "reactive hyperplasia." Associated with enlarged lymph nodes there is usually a marked splenomegaly, weighing 1,600 grams on the average according to Moore.[3] There are diffuse, greyish-white, rough, nodular areas in the spleen similar to that in the lymph nodes.

The lymphosarcomas grossly are the same, and one description suffices for both the lymphoblastic and lymphocytic types. There is characteristically enlargement of a chain or group of lymph nodes instead of single ones. The capsule is thickened and commonly invaded by tumor tissue. Fusion of glands is frequent. As a result of this fusion and infiltration the nodes are not movable. The enlargements are painless unless they impose on some sensitive structure. Ulceration and necrosis of the overlying mucosa or skin is likely. In lymphosarcoma there is usually very little evidence of metastatic foci; when aberrant foci are prominent a leukosarcoma is usually present. Bone marrow is rarely if ever involved. Organs such as lung, brain, heart, liver and kidney may contain greyish-white granular heteroplastic foci. Because of the location of aberrant foci, tumor emboli are supposed to pass through the blood.[4] On section of the involved tissue a homogeneous, granular, greyish-white, bulging tumor is seen. The spleen may or may not be enlarged in lymphosarcoma; if it is, the foci of tumor resemble those of the lymph nodes. The various clinical subvarieties are pharyngeal, gastrointestinal, retroperitoneal, lingual, and testicular, depending on the location of the prominent tumor growth. Necrosis of these tumors is not common but may occur if they outgrow their blood supply or invade blood vessels.

Grossly a reticulum-cell sarcoma, including the stem-cell lymphoma and clasmatocytic lymphoma, is indistinguishable from that of lymphosarcoma.

Hodgkin's granuloma usually involves the cervical lymph nodes first. These enlarge to such an extent as to resemble a large collar-like swelling of the neck. Besides the "cervical" subvariety other types occur and according to Ewing[4] these are dependent on the duration of the process and the site of the lesions. Thus, there are acute, chronic, splenic, gastrointestinal, abdominal, Mickulicz', bone marrow, dermal, and other less common types. Hodgkin's granuloma gives discrete enlarged nodes. The capsule is only slightly thickened or not thickened at all. In the early stages infiltration of the capsule is not observed; this occurs later, however, when sarcomatous changes appear. Then the enlarged glands become matted loosely together. The nodes are mostly soft and on section show in the early stages a gelatinous, somewhat opaque greyish material. Later the tumor becomes opaque and greyish-yellow. In the late sarcomatous stage necrosis and hemorrhage are not uncommon. The tumor tissue has been likened to "fish flesh." The more malignant the tumor the less frequently are metastases found. Aberrant or heteroplastic foci, if found, resemble the primary tumor tissue. In the spleen large patchy nodular areas may appear which are "suet-like" in consistency, opaque, and greyish-yellow, commonly with necrotic areas. In the liver small nodular tumor patches may mottle the capsule and parenchyma which resemble the tumor tissue in the nodes. Other heteroplastic foci, whether granulomatous or sarcomatous, resemble the described characteristics respectively. When the spleen is involved the capsule is usually thickened and covered with adhesions.

Changes in lymphoid tissue in myeloid leukemia are not primary. The spleen is commonly markedly enlarged and may have infarcts; it is firm and dark red. The liver and other viscera may show greyish-white nodules or streaked areas of infiltration, and usually the liver is enlarged. Lymph nodes are not grossly characteristic in myeloid leukemia but usually are moderately enlarged.

Endothelioma of lymphoid tissue is stressed emphatically by Ewing,[4] less so by other authors. The lymph nodes show solid tumors which may reach considerable dimensions. More than one node is commonly involved, and the tumor may become systemic. Tuberculous nodes are confused most frequently during the early stage of the lesion; later carcinoma may be distinguished with difficulty. Rarely is the tumor cystic. Endothelioma of the spleen has been observed by Weichselbaum and Lazarus and Marks,[5,6] in which the tumor was of a multiple cellular, angiomatous type. The systemic form is characterized by simultaneous enlargements of chains of nodes. These glands are smooth and firm at first; later they become hard and on section have an opaque greyish appearance in which necrotic areas may be seen. Fibrosis occurs, and the tumor mass becomes hard and may be completely replaced by the fibrous tissue. The local form is characterized by circumscribed nodal masses with free capsules. As they enlarge they also become harder and there may be multiple node involvement as well as adherence between adjacent nodes. These tumors are of slower growth than carcinoma; and the local form may be compatible with many years of life, whereas the systemic type is usually fatal within a few years. Heteroplastic foci may appear in the liver, spleen, and other nodes, and these resemble the primary involvement.

MICROSCOPIC PATHOLOGIC ANATOMY

"Reactive hyperplasia" or acute lymphadenitis varies with the severity of the infected focus. The tissue is usually infiltrated by many polymorphonuclear leukocytes which crowd the sinusoidal spaces. Suppuration may occur, and necrosis is characteristic of certain type infections such as tuberculosis and tularemia. There is a hyperplasia of lymphocytes and reticulo-endothelial cells. Chronic lymphadenitis is mainly proliferative instead of exudative, and there is marked proliferation of reticulo-endothelial cells; fibroblastic proliferation may eventually replace the lymphoid tissue.

The lymphocytic lymphosarcoma is composed of normal appearing lymphocytes in a homogeneous monotonous pattern. Mitotic figures are rare, but the nuclear chromatin is dark and clumped. The cell is smaller than the lymphoblast, being about 7 to 10 microns in diameter. Giant cells are rarely if ever found. Stem cells may occasionally be seen but are not numerous. Invasion of the node capsule is infrequent. Very little reticular stroma is observed

Giant follicular lymphoma is characterized by growth of lymphoid follicles throughout the node with utter disregard for limitation to the cortex. It is unusual for the follicles to invade pericapsular tissues, but if this does occur new follicle formation is characteristic. The follicular overgrowth causes obliteration of trabeculae, stretching of the reticular stroma, and compression of the sinusoidal spaces. As a result, prepared sections may show separation from the surrounding tissues giving a "cracked-up" appearance; Gall and Mallory[7] give this as a diagnostic criterion. The interfollicular tissue is composed of crowded lymphocytes. Occasionally the follicles may fuse, obliterating the interfollicular lymphocytes, and this fusion may lead to a lymphoblastic lymphoma. Giant cells are not common, and inflammatory cells are not usually seen. Because of the likelihood of these tumors to develop into lymphosarcoma Gall and Mallory[7] call them "a manifestation of malignant lymphoma."

The stem cell lymphoma is apparently derived from cells found in the germinal centers of the follicles. These cells are large and measure 15 to 35 microns in diameter. The cytoplasm is abundant and pale-staining, with poorly defined outlines. The cells may have a syncytial arrangement. The nuclei are vesicular without chromatin clumping but with large nucleoli. The cellular structure has a homogeneous appearance, and there may be no distinct cellular separation, or, on the other hand, the cells may be discrete. Some lymphocytes and monocytes may be found intermingled. The reticular stroma is not abundant.

Clasmatocytic lymphoma consists of large cells smaller than the stem cells, being about 14 to 22 microns in diameter. The cells have slightly eosinophilic cytoplasm with irregular amoeboid-like borders. The nucleus may be eccentric, has a fine chromatin net usually without nucleoli. The nucleus of the clasmatocyte is round, oval or reniform. Lymphocytes may be intermingled amongst the other cells. Collagen and fibrillar tissue may be found but is not abundant. There may be giant cells, which may cause confusion with Hodgkin's disease.

The histopathology of Hodgkin's granuloma varies from place to place and depends on the duration of the lesion. The structure is markedly pleomorphic and consists of neutrophils, eosinophils, plasma cells, lymphocytes, monocytes and fibroblasts. Most characteristic, however, is the stem cell which may be multinucleated. The cytoplasm of the giant stem cell of Sternberg-Reed is abundant and may be basophilic or acidophilic. The nuclei are large and each contains a nucleolus which is dark and may be vacuolated. Mitoses may be present. The multinucleated forms frequently show internuclear bridges. If the disease progresses far enough, the fibroblastic reaction may replace the node and give it a fine white appearance grossly with wide bands of collagen and fibroblasts microscopically. There is a tendency to focal necrosis, and as a result phagocytes are common.

Hodgkin's sarcoma may develop from a Hodgkin's granuloma or appear primarily. Microscopically it consists predominantly of multinucleated Sternberg cells without syncytial arrangement and containing nuclei with many mitotic figures. Eosinophils, lymphocytes, and neutrophils are present but not numerous. Clasmatocytes are occasionally found and may show neoplastic changes. Fibroblasts are not numerous and merely form the collagen background for the tumor stroma.

In myeloid leukemia the pulp cords of the nodes first show increase in size by the appearance of myelocytes which gradually distend the cords, obliterate the sinuses, cause passive atrophy of the lymph follicles and even infiltrate the capsule or pericapsular tissues. Giant cells and nucleated red blood cells may be present, but in more pronounced lesions only large myelocytes are seen. The splenic and other lymphoid tissue changes are similar to those in the lymph nodes. The bone marrow is the primary site of the lesion and is markedly hyperplastic.

Endothelioma of the lymph nodes may at

first resemble a granuloma and later a carcinoma. Characteristically the cells are arranged in groups of "coherent syncytial sheets of cells."[4] The cells have large hyperchromatic nuclei and small nucleoli. The margin of the cellular cytoplasm is indistinct and in this way forms the syncytial sheets and groups of cells. The lymphoid tissue may be obliterated and completely absent. The cells are either elongated or polyhedral, and the cytoplasm is pale. Fibrosis may intersect the tumor tissue and give it a plexiform or alveolar appearance. Giant multinucleated cells are occasionally observed.

The majority of these tumors have common characteristics, and therefrom results the tide of confusion which has come from discussion of them.

RELATIONSHIP OF LYMPHOMAS TO LEUKEMIA

The distinction between lymphatic leukemia and lymphoma on other than clinical studies is relatively impossible. Studies have indicated that morphologically the changes in lymphoid tissue are the same in lymphatic leukemia and lymphoid tumor, particularly lymphosarcoma.

The relationships between lymphosarcoma and leukemia were observed by Sternberg,[4] and because of the frequent occurrence of lymphosarcoma with lymphatic leukemia he called those conditions "leukosarcoma." Both the lymphocytic and lymphoblastic lymphomas are commonly accompanied by lymphatic leukemia. It is proposed that the leukemia appears when there is vascular invasion by the neoplastic tissue.

Besides the leukemic blood change the hematologic studies in lymphoid tumors may show a pseudoleukemia or aleukemia. Pseudoleukemia, as here mentioned, has been used to replace the term "aleukemia," while the term aleukemia replaces non-leuken [illegible] n aleukemia is a blood change, or r [illegible] change, in which no lymphocytosis or [illegible] re blood cells appear. Pseudoleukemia [illegible] to designate the blood when immatu [illegible] s appear in it but unaccompanied by ly [illegible] osis.

The leukemia concomitant with neoplastic lymphoid tissue is usually of the chronic type, whereas acute leukemia is usually coexistent with lymphoid hyperplasia.[4] On the other hand, others believe lymphatic leukemia, both acute and chronic, to be associated almost always with a neoplasia of lymphoid tissue. This discrepancy between two views is not difficult to understand when the distinction of neoplastic from granulomatous or hyperplastic changes is realized to be such a disputed question.

Other lymphoid tumors besides lymphosarcoma may produce leukemic blood changes, but these are distinctly less common.

The relationship of myeloid leukemia with lymphoid tissue has already been referred to, and further discussion is not deemed necessary.

Monocytic leukemia has recently been defined as a distinct entity, but its cell of origin is not definitely known. It seems likely that there is a relationship between clasmatocytic lymphoma and this form of leukocytosis and that a leukemia occurs, as in lymphosarcoma, when there is vascular invasion. The production of monocytic leukemia and Hodgkin's lymphoma by injection of equal quantities of the fractions of the carbinol and non-carbinol, above mentioned, refers to the monocytic leukemia as being a lymphoid process.

SYMPTOMATOLOGY

Regardless of the number of conditions which affect lymph nodes, the general symptomatology is similar for all. There is usually no constitutional symptom characteristic of these diseases. Fever, lassitude, headache, malaise and other generalized symptoms are very seldom found early in the disease but may form a prominent part of the syndrome late in the course of the illness. Pel-Ebstein fever is said to be characteristic of Hodgkin's disease, but it is not commonly observed. The physical findings may be tachycardia, tachypnea, dyspnea and low blood pressure. The respiratory and cardiac distress may be associated with tumor infiltration or be merely associated with a concomitant anemia or cardiac disease. Various skin manifestations are seen but usually not in follicular lymphoblastoma, however. These may include lymphoid or non-specific lesions such as erythema, macules, papules, herpes zoster, petechiae, etc. Pruritus is a common characteristic, particularly of Hodgkin's disease. Brownish pigmentation may accompany or precede the pruritus. Mycosis fungoides was once considered closely related to these diseases, but now it is believed this condition is confused only when the cutaneous manifestations are excessive in a lymphoid disease. Lymph-node enlargement is of course very characteristic, and this may occur anywhere in the body but is commonly seen in the neck. Other times no lymph-node involvement will be found superficially, but there may be massive mediastinal or abdominal involvement. This enlargement is at first discrete and the nodes movable, after which infiltration of capsules occurs and the nodes become matted together. Only in simple lymphoma or reactive hyperplasia is the node tender; other enlargements are painless. In acute lymphadenitis the skin over the node may be hot and reddened. Neurologic symptoms such as pain, paralysis, and compression of the cord or brain are commonly the result of pressure from the enlarged lymph nodes. Paresthesia and other sensory disturbances may occur. The lungs may be infiltrated, and nodular or massive foci may appear. Compression may also affect the lungs, producing atelectasis, or compress the bronchi and produce respiratory distress. The bronchi may be ulcerated over a compressed area. A chylous pleural effusion and ascites is not uncommon. The pericardium and myocardium may be completely infiltrated by tumor tissue, and cardiac distress is not unusual. This distress may be most commonly due to pressure symptoms. Edema or cyanosis may also appear from pressure by surrounding nodes. The gastrointestinal tract may be primarily involved, particularly the small bowel. More commonly the gastrointestinal tract is infiltrated or compressed by pressure from abdominal lymph nodes, and this pressure may produce intestinal obstruction. Diarrhea is not unusual. Splenomegaly and hepatomegaly commonly appear. The ureters may be obstructed by adherent glands with development of a hydronephrosis. The retroperitoneal involvement of lymph nodes may simulate kidney disease, and differentiation is difficult. Hematuria is likely from involvement of kidney and ureter.

Laboratory findings which can be present are increased basal metabolism, anemia, usually hypochromic and microcytic, and lymphocytosis. Hodgkin's disease may show eosinophilia. The blood alkaline phosphatase is increased if the bone marrow is involved.

PROGNOSIS

The duration of these tumors ranges usually between 1 and 5 years. Stem-cell lymphoma has an average duration of 1.7 years, clasmatocytic lymphoma 2.1 years, lymphoblastic lymphoma 1.4 years, lymphocytic lymphoma 3.3 years, Hodgkin's granuloma 4.2 years, Hodgkin's sarcoma 1.8 years, and follicular lymphoma 5.6 years. These figures correspond to the summary of cases, reviewed by Gall and Mallory.[7]

ETIOLOGY

In comparison with the more common type of tumors, such as those of the breast or cervix, the tumors of lymphoid tissue are infrequent. Metastasizing tumors are commonly found in lymph nodes, but it is the primary lymphoid neoplasias which are uncommon.

According to Gall and Mallory,[7] out of 618 cases a third were classed as Hodgkin's granuloma. Lymphocytic lymphoma was the next most common, being found in 22 per cent of the cases. Next in order were lymphoblastic lymphoma (14 per cent), clasmatocytoma (13 per cent), stem cell lymphoma (8 per cent), follicular lymphoma (7 per cent), and Hodgkin's sarcoma (6 per cent).

The average age of onset of these tumors is 43 years. In Hodgkin's lymphoma the occurrence on the average is in a younger age group, 34 years. The clasmatocytic and follicular types are commonest at 49 plus years.

The tumors are most common in males, except for the giant follicular lymphoma and clasmatocytic lymphoma, which seem to be equally distributed in both sexes.

As far as is known, heredity, family predisposition, individual susceptibility, social conditions, and occupation play no part in the tumor etiology. These tumors occur in all races and in all parts of the world. It is felt that in these neoplastic processes, as in others, regardless of what etiologic agent may be involved, a definite susceptibility must be present first.

The distinct etiology is unknown. Much work has been done to determine the causal agents, and many theories have been proposed, but none have clearly demonstrated any specific relationship. Herbut[3] believes the lymphomas may be merely different phases of the same disease process. He found in his studies, and others have demonstrated also, that there may be a transformation between these tumors; that is, one may develop ultimately into the histopathologic lesions of another. Herbut presents 1 case in which reticulum-cell sarcoma, Hodgkin's lymphoma and lymphosarcoma existed concomitantly but in different foci, and other cases showed similar occurrences. He also found that one type of lymphoma may be diagnosed at biopsy yet at autopsy a different lymphoma may be found. Because of these relationships he believes, as stated, that they merely represent phases of the same process.

It is generally conceded that reticulum-cell sarcoma and lymphosarcoma are neoplastic processes, but other lymphomas have been considered as being granulomas. Hodgkin's granuloma has been studied most extensively, and various organisms have been attributed as the etiologic agent. Ewing[4] states that "tuberculosis has followed Hodgkin's like a shadow," and although not going into detail apparently believes there is some relationship between these two diseases. Others have felt that Hodgkin's is due to a diphtheroid bacillus or virus. Recently Forbus, Brown and Kerby[9] have cultured all 3 Brucella organisms from cases of Hodgkin's disease. On intraperitoneal or intravenous injection of Brucella into experimental animals a granulomatous lesion is produced on the peritoneum and in lymph nodes which resemble Hodgkin's in most essentials. The lesions show reticulo-endothelial cell proliferation, eosinophils, plasma cells and giant cells. Ewing[10] believes this reaction to be merely an infectious granuloma resembling but not identical with Hodgkin's in that the terminal fibrosis of Hodgkin's may not appear, and the early lesions are more acute and exudative. Forbus,[10] in supporting his position, states that terminal fibrosis would occur if the process continued long enough in experimental animals.

Medlar[11] suggests that Hodgkin's disease is a megakaryocytoma, a true neoplasm of megakaryocytes derived from bone marrow.

Like other neoplasms lymphosarcoma has been observed to follow administration of indol, estrogens, and 1,2,5,6 dibenzanthracene. Follicular lymphoma, at first considered a benign lesion, is now considered a true malignancy.

The fact that lymph nodes are incited to hyperplasia when draining areas of infection must be considered in the etiology of lymphoid tumors. The suggestion that Hodgkin's granuloma is associated with acute or chronic infections, whether it be Brucella, tuberculosis, virus, or other organism, is important, since Hodgkin's granuloma seems to develop terminally into Hodgkin's sarcoma. It has been observed that acute infections such as tonsillitis have frequently preceded lymphoid tumors, and this, as well as the observation that these tumors frequently occur first in the neck and other areas

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RINGWORM OF THE SCALP*

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RINGWORM of the scalp is still prevalent in this area, and its incidence will undoubtedly increase after the reopening of school this fall. There are many misconceptions about this disease and much controversy concerning its treatment. The purpose of this paper is to offer a brief review of the salient features of the disease and to report our experiences in its treatment by X-ray epilation and by local medication.

Etiology

This disease occurs almost exclusively in children before the age of puberty. Cases have been reported as young as 6 months of age and as late as 17 years of age.[1] The incidence is much higher in boys than in girls.[2] The reason for this is obvious when one considers the habits of boys, i.e., wrestling, hat exchanging, and the patronage of barber shops. We have seen patients of middle age who have been told by their family physician that they have ringworm of the scalp. So far none of these have had tinea but alopecia areata, seborrheic dermatitis, psoriasis, or folliculitis.

There are several species of fungi that produce tinea capitis. Some are primarily animal in type and secondarily transmitted to man. These are more easily cured. Others are of human type and are transmitted only from child to child; these are the more resistant cases. Some fungi fluoresce when exposed to long-wave ultraviolet light. However, fluorescence does not seem to bear any relationship to the resistance of the fungi. This is important to remember, since non-fluorescent ringworm of the scalp has been all too often overlooked.[3]

The fungi affecting the scalp may be classified as follows:

1. *Microsporon group*—all members except M. ferrugineum fluoresce. The infected hairs stand out as brilliant greenish yellow stubs.

(a) M. audouini, human type. This is the most important and causes the greater proportion of the cases of tinea capitis. It is very resistant and requires X-ray epilation.

(b) M. lanosum, animal type. This is less resistant and is frequently cured by local treatment.

2. *Trichophyton group*—

(a) Endothrix (T. crateriforme, violaceum and acuminatum). These are fairly resistant to treatment and often require X-ray epilation. They exhibit low-grade fluorescence, appearing dull bluish in the ultraviolet light.

(b) Ectothrix (T. gypseum and niveum). These organisms usually stay on the surface of the hair and usually respond to local therapy. However, they may penetrate the hair shaft and then are resistant. These organisms do not fluoresce.

3. *Achorion schoenleini*, causative organism of favus. In the scalp this is a very resistant disease and requires X-ray epilation. The organism exhibits a dull greenish fluorescence.

Diagnosis

Usually the first evidence of ringworm is a bald spot on the child's head that is noted by the mother. The hairs in this spot if examined closely appear broken off close to the skin. The patch is either wholly or partly covered by greyish or dark yellowish scales. Less commonly the only evidence of the disease may be scaliness of the scalp. In some cases the disease is characterized by follicular pustules, or the pustules may be collected into an inflammatory swelling of small abscesses known as a kerion.

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The fungi may be demonstrated microscopically by removal of 2 or 3 of the broken-off hairs. These are placed on a slide with a drop or 2 of 15 per cent sodium or potassium hydroxide; a coverslip is put on and the preparation after standing awhile is examined under the high dry lens. The spores may be noted as refractile circular bodies within the hair shaft. These are best seen with the iris diaphragm of the microscope stepped down. The microsporon spores present a mosaic arrangement, whereas the trichophyton spores present a chain formation. The filaments of the fungi are usually not seen in the hairs except in the case of favus.

In doubtful cases and to determine the exact type of fungus the hairs may be inoculated into Sabouraud's media and the fungus identified by culture. A simplified method for fungus culture has been suggested by Bernhardt.[4]

A most important diagnostic aid is the property of fluorescence previously mentioned. The long-wave ultraviolet light is obtained by placing a Wood's filter (a glass made of sodium barium silicate and nickel oxide) over a source of ultraviolet light. This type of apparatus can be obtained from surgical supply houses, or at a much lower cost the "Purplex Bulb" made by Westinghouse Electric Company may be used. This bulb is quite satisfactory if used intermittently for short periods and will burn about 50 hours. The fluorescence is manifested by a brilliant greenish light given off by the affected hair. This is noted to be within the hair shaft and should not be confused with fluorescent scales or fluorescent débris from locally applied medicaments.

DIFFERENTIAL DIAGNOSIS

1. *Alopecia areata.*—The bald patches show smooth skin, without redness or scaliness; the "exclamation point hairs" are present.

2. *Seborrheic dermatitis.*—Usually there are no discrete patches of baldness, and no broken-off hairs. The involved areas are covered by greasy scales or dry non-adherent ones. Often other skin areas are involved.

3. *Psoriasis.*—Thicker and more adherent, "plasterlike" scales are found, and psoriasis is often present elsewhere on the body.

4. *Pediculosis capitis.*—There are no broken-off hairs, but nits on hairs, and lice are found usually if the search is careful.

5. *Bald patches in children* are occasionally seen as a result of pulling out the hair by the child itself or one of its playmates. Some children have the habit of rubbing their heads vigorously against the crib or wall. This may produce some areas of baldness, but in neither case is there inflammation or scaliness.

In none of the above conditions is there any fluorescence in the hairs, nor can a fungus be demonstrated microscopically or be cultured.

TREATMENT

It is generally agreed that X-ray epilation is the most effective treatment for ringworm of the scalp.[5, 6, 7, 8] Moreover, as noted above, in some cases it is the only effective treatment. The epilation must be done by a trained operator on a machine that has been biologically as well as physically calibrated. The most satisfactory technic is still the 5-point Adamson-Kienboeck method which produces a complete epilation of the scalp.[5] The hair falls out in 3 weeks, and regrowth occurs within the next 3 to 6 months. In a properly epilated case there is no danger of failure of the hair to regrow. The only cases (of which we have heard) in which regrowth has not resumed are cases that have been epilated more than once. Hence we feel it most important to stress that epilation should only be done once. This is in contradistinction to the feeling of others.[5, 8]

Partial epilation is mentioned only to be condemned.[9] Although there have been reports of its successful use,[10] we do not think it advisable. There is a grave danger of spread of the infection during the 3-week period before the hair falls out, and there is a good chance of missing some areas of infection even with the most careful examination under the Wood's light. It is most disconcerting to see a child who has been partially epilated get a patch of ringworm in some other area of the scalp. We do not feel such a child should be subjected to the hazard of general epilation after a partial one.

However, X-ray epilation does not kill the fungus; it merely removes the hair in which it lives. It is necessary to use some fungicide to prevent the new hair from becoming infected. For this purpose we have found a 12 per cent sulfur and salicylic acid in petrolatum as effective as any other fungicide. We have the patient use this ointment even before the hair falls out and for several weeks after there is no longer any fluorescence.

Local treatment has in the past been rather unsuccessful. Any method requires many months of treatment, and so far the percentage of cures has not been high. The drugs used have been iodine, sulfur, gentian violet, ammoniated mercury, benzoyl peroxide, quinilor, salicylic acid, tar, thymol, chrysarobin, pyrogallol and mercuric nitrate, in the form of ointments or solutions. They have effected cures in the "animal types" but are unsuccessful in the "human types" of tinea capitis. More recently, proprionic acid with sodium proprionate (Sopronol)[11] as a solution or ointment, salicylanilide in carbowax[12] and trimethyl cetyl ammonium pentachlorphenate (T.C.A.P.) in Intraderm[13] (a penetrating oil) have been tried with great enthusiasm. However, as will be seen in the cases reported below, in our hands these agents have not been highly effective.

RESULTS OF X-RAY EPILATION

We are reporting the past 100 consecutive cases that we have epilated in our office practice. These were done from July 13, 1943 to September 1, 1946.

The following points are significant.

1. Age group: youngest 2½ (girl), oldest 14 (boy).
2. Sex: boys, 86; girls, 14.
3. Fluorescence present in 99, absent in 1.
4. Microscopic demonstration of spores done in all cases.
5. Cures: In 99 cases the hair fell out satisfactorily and all evidence of infection disappeared.
6. Failure in 1 case: A large area of hair failed to fall out, and manual epilation was performed. This was presumed to be due to the child moving its head during the X-ray treatment.
7. Time consideration: In almost all cases the hair has fallen out by the end of the third week after epilation. In a few cases it required an additional week before epilation was complete.
8. In all cases the hair regrew satisfactorily.
9. Complications: In 3 cases the ointment irritated the scalp and was replaced with plain vaseline without any sequelae. In 1 case secondary bacterial infection occurred. Sulfadiazine was given orally and the patient made an uneventful recovery.

RESULTS OF LOCAL TREATMENT

The cases we have treated by local medicaments for a period of time sufficient to be studied fall into 3 groups. There were 11 private office patients, 12 outpatients at Gallinger Municipal Hospital clinic, and 5 patients hospitalized at the Glenn Dale Sanatorium. An analysis of these cases follows:

1. Age group: 20 months to 12 years.
2. Sex: boys, 20; girls, 8.
3. Microscopic demonstration of spores done and fluorescence found in all cases.
4. Drugs used: In almost all cases the following were used in sequence: iodine, Sopronol, salicylanilide, and T.C.A.P. in Intraderm. In 2 office cases (cures) 12 per cent sulfur and salicylic acid ointment was used.
5. Probable cures: 8, as follows:

   Office patients—6
   Clinic patients—2
   Hospital patients—none.

This means a cure in about 30 per cent of patients.

6. Time consideration: Treatment course—1 to 10 months. Average time in the cured cases was about 4 months.
7. Other cases not included: 2 cases of Kerion (non-fluorescent) were treated with ammoniated mercury ointment with clinical cure. There were 12 other office patients who were given only local treatment but did not return to us for a long enough period of time to determine if they were cured or not.

Discussion of Treatment

From our observations we feel that X-ray epilation is at the present the treatment method of choice. It is the most effective method, requires only 3 to 4 weeks of actual treatment, and when properly done is not dangerous to the patient.

We strongly advise against partial epilation since we feel that as the infected hairs fall out they are almost certain to infect other areas of the scalp. If a child that has had partial epilation is subjected to further epilation, there is grave danger of permanent alopecia from overlap. Likewise we are opposed to epilation more than once because of the danger of alopecia.

Local treatment has not been highly successful in our hands even though we have tried many drugs. It has to be used in cases of very young children who can't hold still; in cases of uncooperative children; or in cases in which there has been recurrence after epilation by X-rays.

Obviously it must be used when the parents will not permit X-ray epilation. Cures have been obtained in small patches of tinea capitis that were epilated by hand, and some local fungicide used. The affected area is marked out by a skin pencil under the Wood's light and epilation done in ordinary light by forceps or by use of adhesive tape. An intelligent parent may do this at home after the area has been marked out.

By the most conservative analysis of our cases we can claim only a 30 per cent efficiency for local treatment of fluorescent cases, without regard to the specific type of fungus involved. Other reports of the results of local treatment claim an efficiency up to 70 per cent. Spiller et al[14] with their gentian violet method claim 60 per cent in their cases in general. Livingood and Pillsbury[15] claim that 33.6 per cent of their cases of M. audouini infections were cured with little or no treatment. About 60 per cent of their total number of cases were cured by local treatment alone, and the time of treatment varied from 3 months to 2 years. Strickler[16] averaged from 45 per cent to 70 per cent efficiency by his method of dilute acetic acid and iodine. MacKee et al[13] in introducing the T.C.A.P. in Intraderm treatment report 54 per cent of their cases cured.

We feel that the cases in which local therapy was used are too few to judge the effectiveness of any particular fungicide we employed. Hence we have not gone into detail about the time each drug was used, nor the relative effect from it. However, we feel that our cases do reflect the efficiency of local treatment in general and attest to the relative inefficacy of any fungicide we have tried. The best results we have seen thus far have been from the use of T.C.A.P.

in Intraderm, alternating at 2- to 4-week intervals with Sopronol solution. It was this method of treatment that finally produced cessation of fluorescence and probable cure in half of the cases we report as cures by local therapy.

Our technic is as follows:

1. Clip or shave the hair close to the scalp.
2. Wash the head with T.C.A.P. shampoo, rubbing it thoroughly into the scalp.
3. Partially rinse off with a cup full of warm water.
4. Dry the scalp with a towel.
5. Rub into the scalp the T.C.A.P. in Intraderm solution 5 to 10 minutes, paying particular attention to the infected spots.
6. Repeat this application 3 or 4 times a day every day and wash with the shampoo once a day.
7. After 2 to 4 weeks this is stopped and Sopronol solution is rubbed into the scalp thoroughly 2 to 3 times a day.
8. During this time shampoo the head once or twice a week for the next 2 to 4 weeks.

These courses may be repeated as long as it is felt improvement is occurring as shown by clinical appearance, microscopic demonstration of the spores and fluorescence.

We are continuing to use and evaluate this method of treatment and suggest its use to others who desire to use local therapy for this disease.

Summary and Conclusions

1. A brief review of the salient features of the etiology, diagnosis and differential diagnosis of ringworm of the scalp is offered.
2. One hundred cases of ringworm of the scalp treated by total X-ray epilation are reported. There were 99 per cent cures, 4 complications (3 irritation from the ointment used and 1 secondary bacterial infection) and satisfactory regrowth of hair in all cases.
3. It is recommended that epilation be done only once.
4. Twenty-eight cases treated locally showed 30 per cent probable cures.
5. The most effective local treatment we have found has been T.C.A.P. in Intraderm alternating with Sopronol solution.
6. The average time for treatment of the epilated cases was 6 weeks and that for the locally treated cases was 6 months.
7. From our study it would seem that X-ray epilation for proved cases of ringworm of the scalp is by far the most effective treatment for the disease. When properly administered this form of therapy is entirely safe.

We are indebted to Wallace Laboratories, Inc., New Brunswick, N. J., for kindly supplying us with the Intraderm T.C.A.P. solution and shampoo.

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CANCER OF THE COLON*

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IN 1942 there were 163,400 cancer deaths reported in the United States, and of this number about 10 per cent or 16,340 died from cancer of the colon. After cancer of the stomach the second most frequent site of gastrointestinal malignancy is found in the colon. Different parts of the colon vary in susceptibility. In a series of 625 cases of cancer of the colon reported by Judd,[1] the location was as follows: sigmoid flexure, in 292; cecum and ascending colon, in 159; transverse colon, in 75; descending colon, in 46; hepatic flexure, in 29; and splenic flexure, in 24.

Much has been written regarding the need for early diagnosis of cancer of the colon, but it seems worthy to stress it again. In a sense the disease is a medical problem until it is diagnosed and then it becomes the domain of the surgeon. Irrespective of the location of any cancer it becomes the responsibility of every physician to develop a "cancer awareness" in order to detect the lesions early. It is an academic question whether cancer of the colon is ever diagnosed early. More likely it is the complications of the tumor mass rather than the growths themselves which produce the symptoms. When one considers how many cases there are in which the diagnosis is made late, it is heartening to learn that in one series of 503 cases cited by Lahey[2] 83.5 per cent of the patients could be operated on and 46.3 per cent appear now, after 5 years, to be cured.

During the earlier stages of its development cancer of the colon produces but mild and vague symptoms, but these can be signposts awaiting recognition. To understand the symptom-producing mechanism one must have a knowledge of the anatomic, physiologic and pathologic difference between the right and left side of the colon. Tumors arising in the relatively thin cecal wall are usually fungoid medullary carcinomas growing into the lumen and capable of attaining considerable size before producing signs of obstruction. Also contained in the cecum are liquid fecal material and highly toxic bacteria. The ulcerating growths will ooze blood and give rise to a rather profound anemia, which is the most characteristic sign of malignancy in this area. By comparison, the descending colon and sigmoid segment have a relatively thick muscular wall and small lumen. The feces are firm, and the tumors may be ulcerating, cicatrizing or "napkin-ring" scirrhous carcinomas that constrict the lumen and cause obstruction.

At any stage of its development cancer of the colon may produce an alteration of intestinal function and thereby give rise to a chain of symptoms. Signs of obstruction are manifested early when the growth arises in the left colon. One must be on guard when taking the history. It is a fact that in more than 90 per cent of the cases in which the diagnosis was made the past history presented some clue for 6 months or longer, awaiting recognition or investigation. Many of us are at fault in awaiting the development of a classical textbook picture of "constipation alternating with diarrhea and bloody stools." By this time such manifestations of the neoplasm will frequently be associated with metastasis, and surgery becomes palliative instead of curative.

In peptic ulcer we are fortunate in often having a typical symptom-complex early in the disease. In cancer of the colon we must rely on less definite but none the less valuable information. What is important in the history? The so-called "cancer age" is too indefinite, but the presence of digestive distress, abdominal pain or alteration of bowel habits should be carefully considered as organic in origin before concluding that the basis is psychosomatic. Tentative diagnoses are hazardous and sometimes misleading unless all sources of information have been explored. Cancer of the colon may begin with one or many of the following symptoms: anorexia, slight weight loss, postprandial fullness or uneasiness in the lower abdomen, sporadic mild cramping before a bowel movement, fullness in the rectum, anemia, weakness, slight constipation with occasional bouts of looseness, and the passage of a little blood-stained mucus in the stool. Unexplained anemias warrant particular investigation. Again, the onset of symptoms may be dramatic and ushered in with manifestations of a complete or partial intestinal obstruction. The last 3 personally observed cases are briefly reviewed to stress the difficulties in diagnosis.

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* Presented at the Intensive Postgraduate Course, George Washington University School of Medicine, February 15, 1946.

Illustrative Cases

Case 1.—Mr. R. S., aged 49 years, a patent attorney, was in good health until December 1944, when he developed an intermittent vague aching pain in the right lower abdomen. The bowels moved a little more frequently, but the color and consistency were normal. He was seen 1 month later and reported a good appetite. In fact, he had gained a few pounds in weight. The physical examination including sigmoidoscopy was normal. Gross, microscopic and bacteriologic studies of the feces were negative. Gastrointestinal X-ray examination was reported normal except that the colon showed an extensive filling defect in the transverse colon, about 10 cm. in extent and having the typical appearance of carcinoma, probably of a massive, colloid type. At operation a hard mass was found involving the midtransverse colon. This was resected, and an end-to-end anastomosis was done. The pathologic report was adenocarcinoma, grade 3.

Case 2.—Mrs. A. L., aged 36 years, a housewife, was seen in June 1945 and complained of generalized abdominal pain, nausea and vomiting of 5 days' duration. She had had 3 similar attacks within the past year, but they had been mild and lasted 1 day. There was a history of lifelong constipation and gaseous eructations. Complete blood count showed hemoglobin 65 per cent, red blood cells 3,640,000, and white blood cells 8,500, with a normal differential. On abdominal examination there was marked generalized distention with some tenderness in the right lower quadrant. A scout film of the abdomen showed dilated coils of small intestine located in the epigastric region especially on the left side. This was interpreted as a high degree of intestinal obstruction. Emergency laparotomy disclosed dilatation of all small intestines, cecum and ascending colon. The distal transverse and descending colon were collapsed. An annular carcinoma of the first third of the transverse colon was found, and after cecostomy it was later resected. The pathologic diagnosis was adenocarcinoma (cylindrical cell type), grade 2.

Case 3.—Mrs. C. H., aged 52 years, a housewife, was seen in November 1943, complaining of recurring attacks of lower abominal pain relieved by a bowel movement. There was a history of constipation but no diarrhea. The physical examination including sigmoidoscopy was normal. Stool studies were negative. X-ray examination of the colon with a barium enema showed a long redundant sigmoid extending well up into the region of the splenic flexure and redundancy about the splenic flexure itself. Although there was marked delay in passage of the colonic contents in this area no evidence of an organic lesion could be demonstrated. The diagnosis was spastic, irritable colon, and the patient was not seen again for 1 year. At that time there were anorexia, loss of 20 pounds in weight, and intermittent attacks of dull throbbing pain in the left upper abdomen which occurred particularly 2 to 3 hours after eating. The bowels were moving normally once a day, and there was no history of diarrhea or abdominal distention. Again the physical examination was negative, but the blood count showed a definite secondary anemia and leukocytosis, the hemoglobin being 64 per cent, the red blood cells numbering 3,500,000, and the white blood cells numbering 14,300, with a normal differential count. The colon was X-rayed and reported as follows: "The cecum is markedly dilated, freely movable and not tender to pressure. There is a constant filling defect in the region of the splenic flexure of the 'napkin-ring' type. The appearance is definitely that of carcinoma." At operation a firm nodular mass was found involving the splenic flexure and firmly adherent to the posterior wall in that region. It was inoperable, but a biopsy was taken. The pathologic diagnosis was adenocarcinoma, grade 3.

During 1944 and 1945 there were 28 cases of proved cancer of the colon at the Doctors Hospital in Washington, D. C. A brief survey was made in order to determine and evaluate the clinical picture presented by this group and thus clarify if possible certain characteristics of the disease.

Table 1 gives the distribution of age and sex in 28 cases of cancer of the colon.

TABLE 1

Age and Sex Distribution—Cancer of the Colon

AGES	NO. OF CASES	SEX	NO. OF CASES
40–49	2	Male	12
50–59	9	Female	16
60–69	9		—
70–79	6	Total. . .	28
80–89	2		
	—		
Total.......	28		

With regard to age, the majority of cases occurred from 50 to 70. This is in rather sharp contrast to cases of cancer of the stomach and breasts where the majority are seen in patients of a younger age group.

Table 2 denotes the anatomic location in the 28 cases of cancer of the colon.

TABLE 2

Anatomic Location—Cancer of the Colon

LOCATION OF LESION	NO. OF CASES	PER CENT
Cecum..................	9	32.4
Ascending................	1	3.5
Hepatic flexure...........	1	3.5
Transverse...............	2	7.0
Splenic flexure............	1	3.5
Descending..............	1	3.5
Sigmoid.................	13	46.6
Total..................	28	100.0

The anatomic location is in agreement with other observers. The symptoms were too varied and bizarre to allow an accurate compilation, although all patients complained of some degree of abdominal discomfort ranging from a mild intermittent cramping or aching to a severe constant agonizing pain.

Of the 28 cases 5 were not operated on. The remaining 23 cases were operated on, and 10 of these or 43 per cent had acute intestinal obstruction in the sigmoid. In 7 cases the patients were found to be inoperable because of enlargement, fixation and metastasis of the growth. Of the 23 cases in which exploration was done there were 15 or 70 per cent in which the lesion was resectable and no metastasis was noted. The entire series is somewhat limited in number, but based on the analysis it appears that the search for some early tangible symptom-syndrome was fruitless. However, one takes some encouragement from the fact that nearly 50 per cent could be resected and have a reasonably good chance of surviving without recurrence.

It is generally agreed that no pathognomonic signs of cancer of the colon are apt to appear before the lesion is well advanced. Early in the disease one must depend largely on a careful history and endeavor to employ more freely well established aids, particularly complete blood counts, examination of the stools, proctosigmoidoscopy, and X-ray examination of the colon by a barium enema. Typical symptoms occur late in the disease, and repeated examinations are essential if the patient is not definitely relieved of his complaints after a short period of observation.

A history of vague dyspeptic symptoms, appreciable pallor or anemia without plausible explanation, tendency to intermittent looseness, weakness and possibly an unexplained loss of weight should lead one to suspect a lesion in the colon.

A careful abdominal examination should always be done no matter how time-consuming it may seem. Localized areas of muscular resistance, tenderness or thickening may be significant. In about one third of the cases a tumor mass can be palpated, and one should pay particular attention to the cecum and descending colon. The presence of distention, tympanites, and unusual peristaltic activity may denote partial obstruction. Rectal examination should not be neglected, since about 75 per cent of cancers of the large bowel are within reach of the examining finger or accessible to proctosigmoidoscopic examination. For the digital rectal examination either the knee-chest or left lateral Sims position can be used, and if a growth is palpated its degree of fixation and often its extent can be determined.

Proctosigmoidoscopy is essential in cases presenting symptoms referable to the colon or rectum, and when properly employed it can be done without discomfort or danger to the patient. It is a procedure easily learned and should become a part of the routine study in every physician's office. Preliminary preparation may or may not require a small enema to cleanse the rectal pouch. The patient is then placed in the knee-chest position and after digital examination the sigmoidoscope is inserted carefully and without undue pressure no higher than the examining finger has explored. The finding of polyps, ulcerations, or bleeding might denote associated pathology higher up in the colon and should be a stimulus for further investigation.

Additional examinations of the colon should be made which specifically include the roentgenographic, one of the most important single diagnostic aids. It should be performed by a highly trained specialist in this field in order to attain the maximum diagnostic accuracy. A barium enema and often the employment of the double contrast technic using barium and air will prove invaluable in rounding out essential studies of the colon. Early in the disease cancer of the colon may not be demonstrated with the X-rays, and a negative report might lead to a false sense of security. When symptoms persist, it becomes the duty of every physician to have repeated examinations.

Bockus[3] has summarized the common criteria for the diagnosis of malignant lesions of the colon as: (1) obstruction to the flow of the opaque medium which is persistent despite manipulation and change of position of the patient, especially if the head of the barium column is blunted and hooked; (2) a persistent filling defect whose outlines are jagged and irregular, particularly if the segment of colon involved is not very long; (3) a stricture or annular narrowing of the bowel which is persistent and which does not respond to antispasmodics. In addition to the recognition of the lesion itself, the roentgenograms may yield valuable information concerning the mobility of the mass and its degree of fixation.

Stool examinations are an aid to diagnosis and often furnish confirmatory evidence. Blood may be present in or on the stool, but not until the mucous membrane of the bowel is ulcerated, and unfortunately in many cases this is not an early sign. The presence of bright red blood in or on the stool is pathognomonic of lesions of the rectum or lower left part of the colon, while the finding of occult blood is more significant in the diagnosis of lesions higher up in the gastrointestinal tract. In the vast majority of cancers of the colon occult blood will be present in the stool and not associated with gross bleeding.

Malignancy in the alimentary tract may bleed and cause blood loss or interfere with digestion and absorption. If chronic loss of blood is sufficient in amount, hypochromic microcytic anemia will result. Otherwise normocytic anemia will be found. Marked anemias are usually associated with lesions in the right half of the colon. Where the process is ulcerating an increase in leukocytes and a rapid blood sedimentation rate might be expected.

In the differential diagnosis, non-malignant lesions of the colon must be considered and excluded. Hyperplastic tuberculosis of the colon is usually found in the ileocecal region, whereas segmental ulcerative colitis is present throughout the colon. A suspected diagnosis of actinomycosis, appendiceal abscess, retrocecal appendiceal masses and nonspecific granulomata of the cecum often confuse the diagnosis of early malignancy of the cecum and proximal ascending colon. Associated clinical findings are usually of value in definitely determining the etiologic agent causing the obstructive picture. Diverticulitis with perforation may simulate an obstructive carcinoma of the sigmoid in the early stages; however, clinical study usually permits a fairly accurate differentiation.

TREATMENT

Inasmuch as all of the new chemotherapeutic measures have failed to retard or influence the development of cancer of the colon, surgical resection continues to be the method employed in treatment of this disease. The use of irradiation with X-rays or radium on a primary colonic growth is valueless. If attacked surgically before metastasis has taken place a longer period of cure can be expected than in cancer of any other part of the gastrointestinal tract.

As in other lesions for which major surgery is indicated preoperative treatment is of vital importance in reducing mortality. It has been observed repeatedly that the successful maintenance of these patients depends on a reasonably accurate estimation of his needs in terms of fluid, electrolytes, and plasma proteins. When such imbalances exist, they must be corrected. Soft foods of low residue and high caloric value are indicated and are usually well tolerated unless a fairly complete obstruction is present. Hypoproteinemia and dehydration are frequently present, and assuming the patient can take only one half to two thirds of a normal diet daily, he can be given 1,500 to 2,000 c.c. of 5 per cent glucose in normal saline solution. To maintain a positive nitrogen balance White[4] recommends the intravenous injection of a protein digest solution in surgical patients. This solution is prepared from an enzymatic digest of a mammalian protein, and after purification the end-product is approximately a 6 per cent solution of protein digest which contains free amino acids and polypeptides. In the presence of a protein deficiency White states that "While it is possible to maintain a satisfactory protein balance with blood and plasma, the difficulty of obtaining a sufficient quantity and the expense has almost prohibited this to the average patient. In order to maintain nitrogen balance after operation, patients frequently require 70 grams or more of protein every 24 hours to satisfy this need. One liter of the protein digest solution contains approximately 60 grams of protein, and can be given parenterally without serious reaction and without great expense." In the presence of severe degrees of anemia repeated small transfusions are indicated. It has been found that the use of sulfasuxidine or sulfathalidine in large doses 3 or 4 days preoperatively has become distinctly beneficial in selected cases. For tumors of the right colon Cave[5] prefers a one-stage procedure in the nonobstructed group, especially when he has been able to place preoperatively the distal end of the Miller-Abbott tube at or near the ileocecal valve. The Miller-Abbott tube[6] has proven of unquestionable benefit in decompressing the terminal segments of the small bowel in obstructive lesions of the right colon, and its use has diminished the morbidity and mortality. Its use postoperatively in 1 case of paralytic ileus observed recently was largely responsible in reversing a grave situation.

This was a case of cancer of the sigmoid in which small bowel obstruction developed after resection.

CONCLUSIONS

In cancer of the colon early diagnosis is essential for the reduction of the present mortality rate. Physicians should develop a "cancer awareness" when seeing patients over 35 years of age complaining of a digestive derangement and use promptly the recognized diagnostic aids, particularly proctosigmoidoscopy and X-ray examination. Persons 35 years of age or over should be taught by an aggressive campaign, national in scope, the necessity and value of periodic health examinations.

(*Continued on page 637*)

President's Page

LET US NOT BE MISLED

Significant as were the results of the last election, the medical profession should not misconstrue their meaning. Undoubtedly, there is much less likelihood of unwise legislative action in so far as medical practice is concerned. But let us not delude ourselves into the belief that we need no longer be concerned about needed changes in medical care. It is still our responsibility to find a solution for them. To sidestep our responsibilities now would be to invite serious consequences.

What are some of the medical care problems that must somehow be solved? There is no denying the fact that hospitalization is too expensive for the average individual. The over-all cost of adequate medical service is also too great a burden for the person of ordinary means. If a solution can be found to these problems without impairment of doctor-patient relationship, medicine in this country will lead the world in both quantity and quality.

Our prepayment medical service plan should go a long way toward solving some of the difficulties incident to the distribution and costs of medical service in the District of Columbia. It is, of course, essential that a large proportion of the population be "sold on the idea" of prepaid medicine. This, in itself, is no small undertaking.

Fortunately for us, Group Hospitalization, Inc., has laid the groundwork in prepaid hospitalization. This organization has been most successful in every aspect of its undertaking. It has enrolled over 300,000 employed persons at minimum fees, it is financially sound, and most efficiently administered. As our members know, we are trying to bring about an arrangement whereby the business affairs of our prepayment plan will be administered by Group Hospitalization. This would go far toward assuring the success of the Society's plan.

Before closing this month's message, I wish to make brief mention of another very important project of our Society. We are one of the sponsors of what is known as the Interprofessional Conference of the District of Columbia. Participating in the Conference are representatives of the dental, nursing, pharmaceutical, and hospital organizations. The Conference's objective is to bring about closer coöperation between organizations in the allied fields. This seems to me a most worthy undertaking, one which members of the Society may follow with considerable interest.

William P Herbst Jr

Editorials

THE SECOND PEACETIME CHRISTMAS

In the lifetime of most mature adults there has never been a period in which there has been more dissatisfaction, turmoil and violence than at present. One cannot pick up a newspaper or listen to the radio without being depressed by what one sees and hears. There is, indeed, very little sunshine in the news these days.

However, at Christmas time, we enter quieter waters. Here we find welcome relief from the world's troubles. Forgotten, at least temporarily, are the greed and materialism of our times. So are suspicion and anger which have so torn the world asunder.

Christmas brings to a weary world the assurance that there is still hope for humanity. For the spirit which it generates is one of charity and good will. In this atmosphere, we can reflect more calmly on what is in store for our country, and for that matter, the world, whether it is to be chaos or sanity. We see humanity in better perspective and know that down through history good eventually prevails over evil. We know that the Christmas spirit has far greater power for good than armies or the atomic bomb.

This Christmas we are afforded a great opportunity, whatever our faith, to spread good will among the people. Each of us has influence for good. If we all exercise it to the extent of our ability, subsequent Christmases should be happier for all the peoples of the world.

Physicians can carry the message of good will as few others can. They enter many homes whose doors are closed to others. By their example they can exert influence on countless lives. Few are in a position to make a greater contribution to the world's peace and happiness.

COURSES IN MEDICAL JURISPRUDENCE*

While the courses offered by the medical schools of the United States have increasingly served to equip graduates to deliver a better quality of medical care, they have not to the same extent served to qualify graduates to meet many of the problems that inevitably arise in connection with their practice. The House of Delegates of the American Medical Association gave recognition to this fact several years ago when it recommended that there be included in the medical curriculum adequate courses in the subjects of medical ethics, medical economics and medical sociology. To this triumvirate, I would add a fourth, courses of instruction in the interrelationships of medicine and law. Some medical schools, it is true, offer more or less comprehensive courses in medical jurisprudence but an initial survey made several years ago disclosed that such schools constitute a definite minority group.

During the period when instruction in medicine was being accelerated because of the exacting needs of wartime conditions, it was perhaps not feasible to broaden the course offered by medical schools but now that we at least approach more normal times, attention might well be turned to equipping medical graduates better to understand some of the medicolegal problems incident to practice. Whether or not instruction in this field can more effectively be offered as a separate course or in association with the subjects of the medical curriculum is a matter that invites exploration. It has been suggested that in connection with a course in surgery, the student might be instructed concerning the medicolegal problems that arise in that specialty, such as, for example, the necessity of obtaining consent to operations, or that along with the study of pathology, instruction be given in the legal aspects of autopsies, or that in a course of instruction in pharmacology, the legal restrictions on the use of narcotics and other dangerous drugs be outlined, and so on. A course in preventive medicine, too, might well be extended to include instruction in the prevention of malpractice suits which is much more fundamental, I think, than placing emphasis on the defenses that may be available to a physician against whom a malpractice suit has been instituted. The high incidence of such suits, incidentally, point to a definite need that methods of prevention be stressed to a greater extent.

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* This is the tenth in a series of guest editorials by distinguished physicians and laymen. Others to follow will deal with the scientific, social and economic aspects of medicine.

But whether instruction in medical jurisprudence be offered as a separate course or in connection with the usual subjects in the medical curriculum, it seems timely to suggest that more attention be given to the subject by those who are responsible for the formulation of courses offered in the medical schools.

J. W. HOLLOWAY, JR.
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AGE AT SAN FRANCISCO

The average age of delegates at the Ninety-fifth Annual Session of the House of Delegates of the American Medical Association held at San Francisco in July 1946 was 0.4 of a year lower than that of the 1944 House (see table 2).

Three previous articles[1, 2, 3] on this subject have not produced any profound correlations between age and actions in the American Medical Association but have provoked certain thoughts of interest. The last of these articles[3] ended as follows: "An age analysis following the San Francisco meeting next July may be revealing."

This age analysis and a comparison with the 1944 and 1945 figures are offered herewith. The average age change mentioned above appears to be chiefly due to the fact that there were four less delegates than in 1944 (see table 1); all these were in the age group of 60 and over. There were exactly the same number of delegates in the age group 50 to 59 (68 delegates) and the group under 50 (21 delegates). The total age range in 1944 was 36 to 81; this year it was 37 to 79.

In respect to state delegations (table 2), it was noted in the former report[1] that Wyoming had one delegate aged 81 and Maryland had two delegates aged 74 and 76 (average 75). In 1946 Maryland had two delegates aged 58 and 76 (average 65) and Wyoming sent no delegate. Vermont sent the delegation of highest average age this year, having one delegate, aged 79. The state delegation of lowest average age was from Nevada, one delegate aged 42. (Nevada sent no delegate in 1944.) Each territory represented had one delegate: Alaska, age 48; Hawaii, age 44; and Canal Zone, age 37.

There were 27 states whose delegations' average ages were higher than in 1944; 16 states and 2 territories had delegations with average ages lower than in 1944.

There are no significant changes in the averages of the ages of (A) the general officers of the American Medical Association; (B) the members

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[1] Editorial: M. Ann. District of Columbia, 1944, **13**, 344.

[2] Editorial: M. Ann. District of Columbia, 1945, **14**, 414.

[3] Editorial: M. Ann. District of Columbia, 1946, **15**, 29.

TABLE 1

Number and Percentage of 166 Members of House of Delegates by Age Groups, 95th Session, A. M. A., 1946*

AGE GROUP	NO. OF DELEGATES	PERCENTAGE	PERCENTAGE, 1944
81	—	—	0.59
75–79	6	3.61	4.71
70–74	15	9.04	10.00
65–69	22	13.25	11.76
60–64	34	20.48	20.59
55–59	39	23.49	24.71
50–54	29	17.47	15.29
45–49	12	7.23	7.65
40–44	6	3.61	2.94
35–39	3	1.81	1.76
TOTAL	166	100.00	100.00
60 and up	77	46.39	47.65
50–59	68	40.96	40.00
Under 50	21	12.65	12.35
TOTAL	166	100.00	100.00
55 and up	116	69.88	72.35
Under 55	50	30.12	27.65
TOTAL	166	100.00	100.00

* Make-up of House of Delegates is as published in the *American Medical Association Daily Bulletin, Ninety-fifth Annual Session*, July 3, 1946.

Ages are those the individuals attain on their 1946 birthdays. Birth years were found in the American Medical Association Directory, 1942. One Scientific Section delegate's listing gave only year of graduation from medical school (1895); year of birth was estimated at 1875. (If this be in error, the error is probably toward an age less than the real age.)

No delegates were listed from Wyoming, Puerto Rico or the Virgin Islands.

TABLE 2

Age of 166 Members of House of Delegates, A. M. A., 95th Session, 1946

DELEGATION	NO. OF DELEGATES	RANGE OF AGE	AVERAGE AGE OF DELEGATION	AVERAGE AGE, 1944
Alabama	2	65–66	65.5	63.5
Arizona	1	48	48.	44.
Arkansas	2	52–69	60.5	52.5
California	8	48–60	52.5	57.6
Colorado	2	69–75	72.	68.
Connecticut	3	54–58	55.3	55.3
Delaware	1	65	65.	63.
D. C.	1	62	62.	60.
Florida	2	48–58	53.	51.
Georgia	3	57–78	66.3	66.
Idaho	1	61	61.	59.
Illinois	9	41–67	58.9	62.3
Indiana	4	53–66	60.1	56.
Iowa	3	56–61	58.2	61.
Kansas	2	61–71	66.	64.
Kentucky	2	46–65	55.1	55.5
Louisiana	2	59–68	63.1	61.5
Maine	1	58	58.	56.
Maryland	2	58–76	67.	75.
Massachusetts	5*	53–72	62.	64.3
Michigan	5	59–72	62.2	60.8
Minnesota	4	56–71	64.	62.
Mississippi	2	64–68	66.	64.
Missouri	4	55–78	67.3	65.8
Montana	1	70	70.	68.
Nebraska	2	53–60	56.1	58.5
Nevada	1	42	42.	—
New Hampshire	1	50	50.	48.
New Jersey	5	46–62	53.4	58.6
New Mexico	1	71	71.	—
New York	19*	47–73	58.8	62.
North Carolina	2	61–65	63.	58.5
North Dakota	1	57	57.	55.
Ohio	8	41–63	53.2	55.2
Oklahoma	1*	53	53.	59.
Oregon	1	44	44.	48.
Pennsylvania	10*	39–73	58.3	58.5
Rhode Island	1	61	61.	59.
South Carolina	1	51	51.	51.
South Dakota	1	43	43.	64.
Tennessee	2	55–63	59.	57.
Texas	5	39–74	65.2	60.2
Utah	1	60	60.	71.
Vermont	1	79	79.	53.
Virginia	2	54–63	58.1	58.5
Washington	2	54–63	58.1	56.5
West Virginia	2	57–64	60.1	58.5
Wisconsin	3	54–69	60.2	58.7
Alaska	1	48	48.	—
Hawaii	1	44	44.	52.
Canal Zone	1	37	37.	41.
Scientific Sections	15*	46–77	58.7	55.7
Government Services	3	56–63	59.	59.7
TOTAL	166	37–78	59.	59.4

* One delegate absent and therefore not listed.

of the Board of Trustees; and (C) the members of the Council on Medical Service and Public Relations. There is a very slight downward trend in (A) and (C). Individual changes may be more significant (see table 3).

The only statistical conclusion warranted is

TABLE 3

Ages of Certain Officials, American Medical Association

TITLE	1944		1945		1946	
	NAME	AGE	NAME	AGE	NAME	AGE
(A) General Officers						
President	Kretschmer, H. L.	65	Lee, R. I.	64	Shoulders, H. H.	60
Pres.-elect	Lee, R. I.	63	Shoulders, H. H.	59	West, O.	72
Vice Pres.	Seeger, S. J.	57	Molony, W. R.	66	Bortz, E. L.	50
Sec., Gen. Mgr.	West, O.	70	West, O.	71	Lull, G. F.	59
Treas.	Moore, J. J.	58	Moore, J. J.	59	Moore, J. J.	60
Speaker	Shoulders, H. H.	58	Fouts, R. W.	60	Fouts, R. W.	61
Vice Speaker	Fouts, R. W.	59	Borzell, F. F.	63	Borzell, F. F.	64
Editor	Fishbein, M.	55	Fishbein, M.	56	Fishbein, M.	57
Average Age, General Officers		60.6		63		60.4
(B) Board of Trustees						
	Fenton, R. A.	64	Fitzgibbon, J. H.	51	Fitzgibbon, J. H.	52
	Bloss, J. R. (Chm.)	63	Miller, J. R.	59	Miller, J. R.	60
	Roberts, C. W.	61	Roberts, C. W.	62	Roberts, C. W.	63
	Pallette, E. M.†	70	Murray, D. H.	57	Murray, D. H.	58
	Sensenich, R. L.	62	Sensenich, R. L. (Chm.)	63	Sensenich, R. L. (Chm.)	64
	Braasch, W. F.	66	Braasch, W. F.	67	Braasch, W. F.	68
	Irons, E. E.	67	Irons, E. E.	68	Irons, E. E.	69
	Bauer, L. H.	56	Bauer, L. H.	57	Bauer, L. H.	58
	Henderson, E. L.	59	Henderson, E. L.	60	Henderson, E. L.	61
Average Age, Board of Trustees		63.1		60.4		61.4
(C) Council on Medical Service and Public Relations						
	Adson, A. W.	57	Adson, A. W.	58	Adson, A. W.	59
	Leathers, W. S.*		Martin, W. B.	57	Martin, W. B.	58
	Brooksher, W. R.	50	McCormick, E. J. (Chm.)	54	McCormick, E. J.	55
	McCormick, E. J.	53	McGoldrick, T. A.	71	McGoldrick, T. A.	72
	McGoldrick, T. A.	70	Zech, R.	53	Zech, R.	54
	Fitzgibbon, J. H. (Chm.)	50	McVay, J. R.	54	McVay, J. R.	55
	McVay, J. R.	53	Paullin, J. E.	64	Lee, R. I.	65
	Paullin, J. E.	63	Lee, R. I.	64	Shoulders, H. H.	60
	Kretschmer, H. L.	65	Bauer, L. H.	57	Bauer, L. H.	58
	Bauer, L. H.	56	West, O.	71	Lull, G. F.	59
	West, O.	70				
Average Age, Council on Medical Service and Public Relations		58.7		60.3		59.5

† Died.

* Resigned.

that there has been no significant change in the age groups working on behalf of the American physician. The slight downward age trends noted are within the range of biennial fluctuation and will become significant only if continued.

It is possible that changes toward progressive policy may not necessarily correlate with age, or that they may precede marked changes in the average ages noted.

What would happen if the average age of the Board of Trustees were 55, 50, or even 45 remains to be tried.

H. P. R. (Age 52)

WHY A MEDICAL RECORD DEPARTMENT

In every business or industry a certain standard must be met, and this is true of the modern hospital. The American College of Surgeons recognized that it, too, must set up certain minimum standards. This sprang from the need of the College for better and more complete records of the work which applicants for fellowship were performing in hospitals. This dates back to 1918 when a survey was made of hospitals having 100 beds or more; and of the 692 hospitals in the United States and Canada surveyed, 89 or 12.9 per cent were approved. One of the reasons for their non-approval was found in the lack of medical records; for, while some records were kept, they were not always of help when needed. Therefore, as one requirement, there was needed "Accurate and complete medical records filed in an accessible manner, so as to be available for study, reference, follow-up, and research."

Before this need was recognized, a group of five women met in the Treadwell Library at Massachusetts General Hospital in the spring of 1912. They were first known as the "Club of Record Clerks" and later, in 1916, as the "Association of Record Clerks."

Dr. Malcolm T. MacEachern, Director of Hospital Activities, American College of Surgeons, had been advised of the work of this group of women in Boston; and in October 1928, when the American College of Surgeons met in Boston, he invited the record clerks from all over the country to meet with them. Upon the adjournment of this meeting it was decided by the record librarians who were present at this session to meet regularly once a year, and thus an Association was born on October 11, 1928, known as the Association of Record Librarians of North America, which comprised the United States and Canada, and which is now known as the American Association of Medical Record Librarians.

It is the work of each of the members of this Association not only to help train people for this special department in the hospital but to help improve the Medical Record Department in the hospital. Her duties not only include such routine work as making reports concerning admissions, births, transfers, discharges, or deaths of patients, but in addition she also is charged with the responsibility of briefing and transcribing case histories as well as supervision, indexing, and coding of diagnoses, both primary and secondary. Therefore, the medical record librarian has her finger on the pulse of the national health. Far more than a statistician, she is a research scholar; she compiles and analyzes the data necessary for studying the etiology and epidemiology of a malady; she records information regarding diagnosis, prognosis, geographic occurrence, duration, and sequelae of disease condition, and the role ill health may play in the patient's economic and sociologic outlook.

The Medical Record Department furnishes reports for the hospital administrator in order to gauge the work done and the work planned for the future. It evaluates the service of the hospital to the people in its area. Without such information the health resources of the nation would truly be difficult to appraise.

Irrespective of the efficiency of the librarian, she cannot bring her department to an approved level unless there is coöperation throughout the hospital. This means carefully recorded histories, accurate physical examinations, prompt and relevant laboratory data, operative reports in detail, current progress notes, and dismissal sheets complete in all details. This cannot be accomplished without direction and supervision. Those responsible for the completion of records are fully aware of the difficulty in maintaining a high standard and are often discouraged by the apparently uninterested staff. In spite of all this, hospital records are improving each year as the indifference to this important hospital activity seems destined to be replaced by something remotely akin to enthusiasm.

C. S. W.

In and Out of Focus

BY THE OBSERVER

World Medical Association

In view of the difficulties which have beset international organizations in the field of politics, it required courage to undertake the welding together of national medical associations into a world body. But those who gathered for this purpose in London last September were highly optimistic about the future of this vast undertaking. The organization which they established at a three-day conference, held under the auspices of the Association Professionelle Internationale des Médecins and the British Medical Association, will be known as the World Medical Association. Thirty-one countries were represented at the conference by forty-three delegates. Thirty-two observers were on hand from a number of countries not yet participating, among which was the United States.

Objectives decided upon by the new Association, as reported in the *British Medical Journal*, were: "(1) to promote closer ties between the various international medical organizations; (2) to study the problems which confront the medical profession in different countries; (3) to organize exchange of information; and (4) to establish relations with and present the views of the medical profession to the World Health Organization and UNESCO." Lord Horder (observer for the American Medical Association) rephrased the first objective and it was later accepted. It read, "To promote closer ties among the national medical organizations and among the doctors of the world by personal contact and all other means available in order to assist all peoples of the world to attain the highest possible level of health."

The question naturally arose whether WMA should concern itself with scientific medicine. According to the *Journal*, the view prevailed that the Association should not devote its attention to this subject because it "was well cared for by various national academies and scientific bodies." The opinion was expressed by Dr. F. Decourt of France, that one of the primary reasons for establishing the Association "was to defend medical practitioners whose liberty was being menaced in many countries."

As for the other health organizations, such as the World Health Organization and the UNESCO (United Nations Educational, Scientific and Cultural Organization), there was a feeling that these did not fulfill the need for a world-wide organization of medical men and women. It was emphasized that "doctors from more than one country were gravely concerned about the relationship between the State and the medical profession, and were anxiously watching the developments of the medical services in this country, feeling that what happens in Great Britain may have a profound effect on the evolution of medical services in other nations. Membership in a world-wide organization will heighten the sense of responsibility of the numerous national bodies constituting it and will lend overwhelming strength to the constituent bodies when they severally have to deal with the body politic."

WMA chose two secretaries, one from each sponsoring group. French and English, it was voted, should be the official languages of the Association. A committee was appointed to "prepare the ground for the next conference." On this committee is the affable, eloquent Secretary of the Canadian Medical Association, Dr. T. C. Routley. Dr. Routley took a prominent part in the deliberations of the Association, and his remarks apparently carried considerable weight. Despite the existing world organizations, he said, there was now room in the United Nations for an organization of medical associations parallel with that which had resulted in the World Health Organization. The new organization, he said, "would signify the unity of the doctors all over the world." It should know no geographic boundaries, and should have as its primary objective assisting mankind to obtain the highest possible level of health.

The next conference of the Association is scheduled to be held in Paris, the date and the program yet to be decided.

Considering the vexing problems confronting medical men throughout the world, the WMA will not lack opportunities to justify its existence. However, until the AMA decides to become an active member of the Association, interest of physicians in this country in WMA will be largely academic. Undoubtedly, this is a matter which will soon come before the AMA's House of Delegates.

Medicine Becomes a Social Science

Perhaps the most provocative and stimulating series of articles on social and economic aspects of medicine are currently appearing in *New York Medicine* under the caption, "The Next Ten Years in Medicine." All shades of medical opinion have been welcomed by this journal, a policy for which the editor should be highly commended. One of those invited to express his views was Dr. Willard C. Rappleye, Dean of the College of Physicians and Surgeons of Columbia University. Dr. Rappleye is widely known in medical circles for his liberal views. One may or may not agree with all of Dr. Rappleye's conclusions, but no one can deny that he is vigorous and constructive. Of particular interest to readers of this column should be his comments on sickness insurance.

Space will not permit publication of all of Dr. Rappleye's article, "Current Trends in Medical Care." However, the following excerpts will serve to make his views clear:

> "Since the inauguration of various voluntary plans. . . a number of nation-wide experiments have been tried in Western Europe, especially during the last sixty years. It is interesting to note that many of the present recommendations and efforts of the medical profession and other groups in this country in dealing with prepayment medical programs have ignored or disregarded the actual experiences abroad. As an example, the proposals by the medical profession for medical care insurance are on a 'cash benefit' basis for partial medical services on a fee-for-service remuneration rather than on the provision of comprehensive 'benefits in kind.' These metnods are quite contrary to the best experiences and evidence here and elsewhere that would indicate that the proposals are already known to be impractical and unworkable.
>
> "Many of the policies being written by medical society programs are almost identical with the policies written by the commercial casualty indemnity companies. It is difficult to see why the medical profession is entering into a field of indemnity insurance already covered expertly by some of the leading insurance companies in this country. The only justification for the medical profession entering into the insurance business is to provide 'benefits in kind' in the nature of comprehensive, adequate medical services, leaving the cash indemnity business to the commercial companies.

> "Another consideration of importance is that of the administrative responsibility in the conduct of prepayment medical services. The medical profession insists upon the control of any medical service program. It is obvious, however, that the responsibility for providing adequate medical care for the country is not merely a professional responsibility. Any adequate plan must embrace the interests of labor, business and the public as well as the professional groups. Industry, banking, labor, the medical and other professions, the hospitals, public administration and other interests should be represented. The purely professional matters must, of course, be left in the hands and to the judgment of the doctors and other professional workers who by training, skill and experience are qualified to make the best decisions regarding professional services.
>
> "It is important to emphasize that local administration of a program is essential to full success. Only through actual local direction will it be possible to adapt medical service plans to meet the needs of individuals and of the community in which these services are to be rendered."

Your Observer cannot go the whole way with Dr. Rappleye in regard to the administration of prepayment plans. Certainly, consumers should have a voice in the conduct of these plans, but not a predominant one. As to Dr. Rappleye's views on "cash benefit" plans, your Observer is in entire agreement.

Dr. Rappleye concludes his article with these observations:

> "Medicine today is as much a social as it is a biological science. The doctor is not merely a technician but must be an important factor in the shaping and guiding of any satisfactory plan of medical service. It has been quite apparent in recent years that the medical profession, so largely concentrating on individual techniques and methods of practice has failed to produce long-term, constructive policies or a sufficient number of public minded leaders who are qualified by point of view or experience to guide the development of sound local and national plans for medical care.
>
> "The country needs wise, courageous leaders in medicine, coöperating with industry, labor and the public to meet the health needs of the country and avoid the errors and mistakes of other health service programs such as have been developed in the last sixty years in Europe. We must develop plans which will be suitable to the needs of American society under the guidance and direction by professional personnel on professional matters."

Medicine and Atomic Warfare

What the speaker or writer thinks is an innocuous or harmless statement may to his surprise have much more significance than had occurred to him. This has certainly been the experience of many a physician. For example, he may present a long dissertation having little interest for the public because of its technical nature. However, there may be a line or two, or a few paragraphs, which find their way into the newspaper headlines. They may give a distorted view of what the physician wished to convey, emphasis having been placed where he did not intend it to be.

This situation came to mind when your Observer read a news report on an address by Dr. Michael E. DeBakey, Associate Professor of Surgery, Tulane University School of Medicine, at the Massachusetts General Hospital last October. His subject was "Military Surgery in World War II." Dr. DeBakey presented a review of military medicine, made no bones about Army Medical Corps' mistakes, and applauded its triumphs. He deplored the Army's failure to learn lessons from its previous experiences, and at the very close of his address warned his listeners what may be in store for them if this country finds itself in another war. It was at this point that he made the headlines. Here is what he said:

> "The problems of a possible third World War, about which we shall be criminally negligent if we are not entirely realistic, are likely to exceed to a staggering degree those of World War II. The end of the second World War may indeed have marked the end of an era in military surgery. For centuries, military surgery has followed a pattern which, although progressively more demanding, was still essentially similar. Much of the knowledge we now possess, however, may become irrelevant and useless in this new era. There will necessarily be a new concept of war wounds. Radiation, blast, and burn injuries of atomic origin will pose problems of management different from those hitherto associated with surgical care, and there must be a new concept of traumatic surgery in terms of regional injury.
>
> "Furthermore, the introduction of atomic weapons is likely to wipe out the old concept of echelons of combat

> and areas of security, and to bring civilians and military forces together into a single zone of combat. Atomic warfare is likely to produce an instantaneous flood of casualties, such as no battle in the history of the world ever before produced. It will require the full use of all hospital facilities, on an over-all basis, with no wastage of beds. It will require the strategic placement of all equipment for general use as needed. Above all, it will require the mobilization of the entire medical personnel of the nation on a disaster basis. There can be no distinction between military and civilian medical responsibility, for there will be no distinction between military and civilian injuries. It will require a mobility and speed of assignment of medical and surgical personnel, such as has never before been necessary. There can be no more wastage of physicians. The problem, indeed, may be to keep the medical personnel of the country protected and alive and sufficiently uninjured to carry out its functions."

Of course, the reporters pounced on these "iffy" predictions of things to come, although Dr. DeBakey qualified the preceding statement as follows:

> "I do not believe that so dark a future will come upon us soon, or that it is inevitable. But we should be lacking in realism and deserving of our fate, if we did not face the possibilities frankly, if we did not take steps to forestall and prevent disaster, and to prepare for it should it come upon us."

Dr. DeBakey closed with a plea for necessary changes in medicine, not only in medical education and graduate education, but in medical practice. The relationship and attitude of the civilian medical profession toward the Federal medical services, including the Army and the Navy, he said, left much to be desired.

No one can quarrel with Dr. DeBakey's observations, although it is depressing to have to admit the need to prepare for a possible world conflict. Things being the way they are, this seems to be the only safe course to pursue.

* * *

A Dearth of General Practitioners

Deeply concerned about the decrease in the number of general practitioners in his state, Dr. C. A. Dawson, President of the State Medical Society of Wisconsin and a member of the State Medical Board of Examiners, recently addressed his fellow physicians on the subject, "Is Overspecialization a Threat?" Dr. Dawson reports that upon questioning applicants for licensure, many of them formerly with the armed services, it was learned that only 10 per cent intended to do general practice, 90 per cent stating that they proposed to specialize. In the course of private conversation applicants said that the following factors had influenced their decision to enter special fields:

> "1. That they had been assigned to specialized service under a specialist in one certain field and had become impressed by the type of work that had been done by that individual. Having had some experience and training along that line they felt that they should not waste the knowledge that they had thus acquired.
>
> "2. That there was much more opportunity for large financial gain in the specialist fields than in the field of general medicine.
>
> "3. That in the specialist fields the work was not so arduous—that night work was seldom necessary (except in the field of obstetrics), and that, with their work being almost entirely hospital and office work, much more time could be devoted to cultural advancement and to social and recreational pursuits.
>
> "4. That there is an increasing tendency on the part of hospitals to limit their staffs to specialist board rated men. These men pointed out that without specialty rating they would have little or no possibility of being able to hospitalize their patients under their own service and administer to them their own treatment. It was the thought of these men that as time passed the opportunity for general practitioners to obtain staff appointments would become more and more difficult. In certain cities and in certain excellent institutions this condition has indeed become fact. No argument can controvert the fact that the general practitioner, for instance, who is forced to turn his obstetric cases over to an obstetrician for delivery and the newborn babe to a pediatrician in order for them to get hospital care, is being handicapped.
>
> "5. One more reason that the young man looks askance at the general practice of medicine is that, in his opinion, the prestige of the specialist is steadily mounting while that of the general practitioner is suffering a corresponding decline.
>
> "All of these reasons seem important to young men, and indeed they are. Theirs is the task of mapping out their future. They hesitate to hitch their wagons to a falling star."

Pointing out the seriousness of the situation which exists in his state because of the decline in the number of general practitioners, Dr. Dawson calls attention to diverging opinions with respect to specialization. On this point, he concludes:

> "Medicine today is in a vortex which has been created by its own progress. As the profession becomes more and more exact, specialism becomes more and more necessary and it becomes more and more difficult for the patient to obtain comprehensive medical care. When specialism has developed to the point where the whole man is being treated by different types of specialists who have little or no common ground upon which to stand, specialism will have become a dangerous thing. No one would decry the necessity for specialized knowledge, but some way must be found to integrate specialism into comprehensive medical care.
>
> ". . . The problem is one that concerns all of medicine. The causes, in relation to the effect, should be studied, and the solution, or solutions, discovered. No one man will find the answer."

★

Significance of the November Election

It is to be hoped that medical men will not be misled by the Republican victory at the polls in November. There is real danger that a good many of them will feel that the New Deal being dead, there is no longer danger that health legislation objectionable to the profession will be enacted. Of course, nothing could be further from the truth.

What the election means to the medical profession is that it has been given a breathing spell for the next two years. It is safe to say that no health legislation similar to the Wagner-Murray-Dingell bill will be seriously considered by the next Congress. Nevertheless, Republicans, who now control both the Senate and the House, are on trial, and they know it. It is well to remember too that labor helped elect the Republicans, and they are not going to lose sight of this fact before the next election. It will not be too surprising if favorable consideration is given social legislation, some of it perhaps relating to medicine. The so-called Taft Health bill will receive a hearing, and in a modified form. Let it also be understood that none of the health legislation enacted during the Roosevelt régime will be repealed. Republicans are too realistic to undertake that, nor is there any particular desire on their part to do so.

What is far more important than the political aspects of the election is the fact that the next two years will offer the medical profession a golden opportunity. During this period, organized medicine will be given time in which to make its national health program a reality. Prepayment medical plans, whose success to date has been dubious, will be given another lease on life. Medical societies which are just getting under way with their plans or have not made a beginning will have ample time to make a go of them. Needless to say, there are other aspects of health planning also in need of attention—group practice, diagnostic clinics, and improved methods for the care of the indigent.

Now is the time for vigorous and intelligent medical leadership to assert itself. If full advantage of the "breathing spell" is taken, the organized medical profession will be in a most satisfactory position when 1948 rolls around.

★

Why Not Another Organization?

The increase in the number of organizations is appalling. This is just as true in medicine as in any other field. As might be expected, most of them clamor for the attention not only of their members, but of those outside their ranks, chiefly because they cannot maintain their programs without outside support. In consequence, nearly everyone of any importance is so bombarded with notices, invitations, and so on, that he throws up his hands in despair. Where will all this end?

The other day, a physician dropped into your Observer's office for a moment's conversation. Discussion veered to organizations and meetings. The physician suggested that now that we have medical societies devoting their attention to specific diseases, it might be well to organize groups confining themselves to separate parts of the body. Why not one concentrating on the hands, another on the feet, and so on. Sounds silly, doesn't it? But one can never tell.

Seriously, physicians cannot keep on with this sort of thing. There aren't that many hours a day, or evenings a week. Frequently, your Observer has heard a physician say that he hasn't been home an evening during the week. He has attended meeting after meeting of regular and special medical societies, hospital staffs, and medical school faculties. In addition, he has participated in civic activities.

Now, if these groups were content with a modest program, it would not be so bad. But all of them feel that they must expand. Several put out publications which require a great deal of time and effort. Needless to say, there is much duplication of effort. But the physician cannot disengage himself, or at least he thinks he can't because of loyalty to the various groups.

Sooner or later, this situation will be found intolerable. Only then will there be coördination and a combining of the efforts of medical organizations.

Now, it is understandable that physicians in the District of Columbia, most of whom restrict themselves more or less to a specialty, wish to meet with colleagues who have like interests for the purpose of discussion. However, there is no reason why all organized groups devoting themselves to specialties should not become a part of The Medical Society of the District of Columbia, so that activities could be correlated and as much duplication avoided as possible. On occasion, meetings could go on simultaneously, but all would be under the auspices of the Society.

Your Observer is well aware that there is considerable sentiment with regard to many special medical organizations in Washington, and that their identity will undoubtedly always be maintained. The point he wishes to make is that the sharp increase in these and other medical organizations may have serious consequences to physicians themselves. There is a limit to the time and effort which they can devote to outside activities. That limit may be reached before they realize it.

★

The Presidency Takes Its Toll

Why do men seek the Presidency? There are many reasons, most of them obvious. A desire for eminence, an ambition to excel, and a wish for power, are among them. Undoubtedly, a majority sincerely believe that they can be of great service to the Nation.

Among the reasons for wishing to be President, the desire for good health and longevity is conspicuously absent. No man seeking to become Chief Executive who is honest with himself can escape the conclusion that he must pay a heavy price physically for the honors that go with the office. Recent incumbents of the White House especially have aged rapidly under the terrific burdens they have carried. Few of them have lived out their expected span of life. This is borne out by facts presented in an article, "Does the Presidency Shorten Life?" appearing in the *Statistical Bulletin of the Metropolitan Life Insurance Company* for October, 1946.

"Only twelve out of thirty deceased Presidents," the *Bulletin* states, "outlived their expectation of life at inauguration, and the long-lived executives were concentrated, for the most part, in the earlier period of the Nation's history." Of the first ten Presidents, it is pointed out, eight lived longer than might have been anticipated, considering mortality conditions at that time. Exceptions noted are George Washington and William H. Harrison. Of the Chief Executives since 1900, William Howard Taft survived his expectation of life at inauguration, and Herbert Hoover, the only living ex-President, has nearly attained this point. Harry S. Truman, the *Bulletin* says, has several years more before reaching the expectation of life reckoning it from his inauguration.

What makes the responsibilities of the Presidency so sinister where health is concerned is the fact that most Chief Executives are elected at or past middle age, when they become subject to degenerative diseases. The youngest President was Theodore Roosevelt, who was 42 years old when inaugurated. Five were between 45 and 49 years; eleven between 50 and 54; nine between 55 and 59; four between 60 and 64; and only two were over 65. President Truman is the only Chief Executive since Buchanan, inaugurated in 1857, having passed his 60th birthday before inauguration.

Mortality among Presidents makes it quite clear that increasing demands on them, due to the complexities of modern life, have had serious effect upon their span of life. On this point, the *Bulletin* observes:

> "It was found that the Presidents who took office before 1850 outlived their expectation of life at inauguration by an average of 2.9 years. On the other hand, the Presidents who served from 1850 to 1900 fell short of their expectation of life at inauguration by an average of 2.9 years. The deficiency is increased to about six years when the three Presidents who were assassinated are included in the computations for this half century. The Presidents who have held office during the present century have made an even poorer record; their length of life since inauguration has been, on an average, eight years less than their expectation of life at the time of taking office. Even if allowance is made for the exclusion of Herbert Hoover from this group, the difference is still appreciable."

There have been suggestions from time to time that steps be taken to relieve the President of some of the intolerable burdens of his office. To date nothing has been done. Congress should take a hand in this matter without delay. Our people can ill afford to lose the services of men who have guided this country, whether for better or for worse. For their experiences have been invaluable and it is to the people's interest, as well as to their own, that they live to a ripe old age.

Retirement Rules Condemned

As everyone knows, ours is an aging population. The number of persons who now reach the usual age of retirement, 65, is rapidly increasing. This situation will inevitably give rise to demands for a reappraisal of their place in society. Otherwise, there will be growing discontent among those of retirement age who are still physically and mentally fit. These individuals can see no good reason why they should not carry on as in the past when they are perfectly capable of doing so. And they have a lot on their side. It is common knowledge that physical deterioration does not follow the calendar. Some are old despite their youth in years, and vice versa.

Dr. Theodore G. Klumpp, President of the Winthrop Chemical Company, spoke his mind on this subject when he addressed the American Public Health Association at its annual meeting on November 14. Dr. Klumpp, a capable, outspoken physician-executive, predicted that by 1980 "there will be not less than 60,000,000 Americans 45 years and over, and more than 21,000,000 who are 65 and over."

> "Society," he said, "has been quite illogical and inconsistent in its attitude toward the older worker. On the one hand, we have no objection to electing and appointing older individuals to positions of greatest responsibility in government, business, and the professions. And yet, as far as the rank and file of workers is concerned, we impose blind, and unselected compulsory retirement rules which automatically eliminate those in the ranks who have reached a certain age regardless of their fitness, ability and contribution to the group for which they labor."

Directing attention to the great advances in industry and in government in the last decade, Dr. Klumpp asserts that we have only made a beginning. He proposes that the major burden of these advances "can be carried by the extension of voluntary retirement plans in which the employer and the employee share the cost." Moreover, he said, "not only much more realistic retirement benefits are required, but such plans must be more widely adopted by employers generally."

Dr. Klumpp presented the following 7-point program:

> "1. Since physiological age is not synonymous with chronological age, compulsory retirement on a calendar age basis should be abandoned.
>
> "2. Since hiring is selective and based on fitness to do a given job, retirement should likewise be selective and based on unfitness.
>
> "3. Compulsory retirement should be based on the recommendation of a retirement board composed of medical and psychiatric members as well as administrative officials.
>
> "4. If wage in proportion to performance is recognized as a fundamental principle, the older worker should taper off in industry, just as the young apprentice gradually works himself up in skill, performance and remuneration. In other words, opportunities for downgrading in position and salary should be offered.
>
> "5. Industry, governmental and private institutions must make a greater and more intelligent effort to employ partially disabled persons.
>
> "6. When the aged and disabled have work to do hey are less of a burden, financially, socially and spiritually to the folks at home. Other things being equal, home environment is better than an institution for the aged and disabled.
>
> "7. Institutions for the aged and disabled must be changed from asylums to modern institutions where every convenience and scientific development is available for their physical, mental and spiritual comfort."

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A.A.P.S. Presents Its Case

Another medical organization now seeks credit for the defeat of national health legislation objectionable to physicians. At least, that is the impression one gets from reading an editorial appearing in the October number of the *Rocky Mountain Medical Journal.* Mr. Harry Northam, Executive Secretary of the Association of American Physicians and Surgeons, it is reported, addressed a medical group in Denver on September 3. He reviewed the activities of the Association, both nationally and in the western states. Attention was called to the Colorado State Medical Society's endorsement of its "motives" some two years ago. Related, too, were the efforts of the Washington bureaucrats and New Dealers to get up some steam behind the Wagner-Murray-Dingell bill. Special attention was devoted to Senator Pepper and his efforts to revive his maternity health legislation. It was then, according to the *Journal*, that the AAPS "inspired an avalanche of telegrams to the Senate Committee on Education and Labor. Thus the Pepper bill died in committee."

"This," the *Journal* continues, "is one of many services rendered to the American doctors since the AAPS's inception." Not wishing the organization to appear immodest in its claims, the *Journal* adds, "By no means is it competitive to the AMA, they augment and check each other."

There follows a discussion about the proponents of the Wagner-Murray-Dingell bill, Government agencies and individuals, most of whom, the *Journal* says, are not physicians.

> "It is to compete with such agencies and misguided individuals as these," says the *Journal*, "that the AAPS was formed by members of the AMA. The organization's first objective is to assure the freedom of American doctors to practice and American people to choose their doctors. Thus organized, American doctors can act as a body, if necessary in ways which the AMA cannot act, in response and retaliation to materialization of a threat which dictates the way in which we shall practice. Secondly, it aims to facilitate and apply principles of voluntary insurance to prepayment plans and to inform all levels of the population of the evils of government control of medical practice.
>
> "No individual or clique can control the AAPS; it is not a labor union. Its members will never strike against a sick public, but will not serve an uninvited usurpation of a federal bureau."

The statement that AAPS can act "in ways which the AMA cannot act" has, in your Observer's opinion, no foundation in fact. It was also used by the National Physicians Committee to bolster its prestige with physicians, and may still be for that matter. Of course, there is no reason why the AMA cannot act in any manner it wishes. In fact, it is its duty to act in the interests of members. Happily, there is growing evidence that the AMA is not enthusiastic about having "outsiders" speak for it.

★

Alcoholics Anonymous To what extent are alcoholics benefited by Alcoholics Anonymous? Many physicians have asked this question. They are particularly interested in knowing what kind of an organization it is, and if its claims can be substantiated.

Alcoholics Anonymous was established by a group of laymen some twelve years ago. Since that time it has grown rapidly, its membership now being about 27,000, all of them former alcoholic men and women. Situated in some 750 American and Canadian communities, they belong to groups ranging in size from half a dozen to several hundred persons.

In answering the question why Alcoholics Anonymous has succeeded where medicine and religion have admittedly failed, Dr. Allen R. Anderson in the *Nassau Medical News* (New York) for September, says that "unbelievable" results were obtained by this organization for the following reasons:

> "(1) The alcoholic had never before been approached by those who knew all the despair of chronic alcoholism. These were kindred spirits, people who understood him.
>
> "(2) Nothing was asked of the alcoholic except that he never take another drink. He was not asked to join a church, nor subscribe to any creed. He was asked to believe that a power greater than he was operating to keep him from drinking, but he could call this power by whatever name he wished. If he were religious he might call it God; if he were not he might call it simply Power Greater than Myself.
>
> "(3) It became apparent very soon that a sudden religious experience, such as the founder had had, was not necessary for cure. In fact, a much slower conversion was more often the case. One of the founders has estimated that 90 per cent of those cured have a slow conversion, and about 10 per cent a sudden conversion.
>
> "(4) Most important of all, each patient in the process of getting well becomes an active participant in an understanding society of ex-drinkers. The alcoholic has always been known as a defiant, egocentric individual who has withdrawn from the 'herd,' and these gatherings persuade him to assume his rightful place in society as a friendly human being. If he falls by the wayside or if he is having trouble in making his conversion complete, he will find sympathy and guidance from those who have traveled the same road. And the old members frankly admit that their resolutions are constantly strengthened by the work they do with the newcomers.
>
> "The hardest step towards recovery the alcoholic has to take is the first, admitting that he is an alcoholic. Strange as it may seem, it is not unusual to see a drunkard go through all the stages of alcoholic deterioration, and to his death cling to the foolish notion that he could drink like other men. He must be convinced from his own experience that his reaction to alcohol is so abnormal that any indulgence for him constitutes a totally undesirable and impossible way of life."

Alcoholics Anonymous claims a recovery rate of 75 per cent of those who conscientiously follow its methods. It is admitted that "the frankly psychopathic alcoholics" are not benefited by its form of treatment, and agreed that these patients should continue under psychiatrists or remain in mental institutions.

What do psychiatrists think of the organization? Dr. Anderson says: "In general, psychiatrists regard conversion as an emotional experience too uncertain for lasting benefits, but at least some of them are willing to reconsider this statement in view of AA's astonishing results "

Your Observer, and he is sure this is true of many of his readers, has made the acquaintance of members of the local unit of Alcoholics Anonymous. He has been deeply impressed by the experiences which they relate. Certainly, in individual instances, this organization has fully demonstrated its usefulness.

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Footnotes The American Legion at its twenty-eighth national convention, held in San Francisco in October, adopted a resolution expressing its opposition to compulsory health insurance. Naturally, medical leaders were elated. As one of them pointed

(*Continued on page 638*)

PREPAYMENT MEDICAL CARE PLANS PROGRESSING

THOMAS A. HENDRICKS

Secretary, Council on Medical Service, American Medical Association

Driving to complete the voluntary health insurance program for the care of the American people is the big job facing local, state, and national medical organizations today. More than 80 plans sponsored by Medical Societies in 33 states covering 4,000,000 persons, are now in operation, and the task has just begun. Responsibility for carrying out this effort has been placed on the council on Medical Service by the House of Delegates. This is one of the most difficult chores officially assigned to any body of the American Medical Association, but as complex and intricate as it is, the Council is confident that the job can be done and that voluntary health insurance rather than any Government-operated compulsory plan for sickness insurance will be able to spread the costs of illness and meet the demands of the public.

The pioneering state of voluntary health insurance is nearing its completion and nationally we are rapidly entering the development stage. Now only 2 states do not have a plan operating or in the process of formation. Plans for a prepayment program are now being made in 13 states and the District of Columbia. Growth of the plans now in operation has been rapid, the over-all expansion within the past six months being as phenomenal a production figure as has appeared in modern insurance records.

The enrollment in prepayment plans has accelerated slowly. This was partly due to the difficulties developed in the early experimentation stages through which such plans had to pass, and partly to hesitancy on the part of doctors to plunge into an untested field of endeavor. As the number of plans has increased, so too has the acceleration in enrollment. During 1945 the over-all increase was 114 per cent. For the first six months of 1946 the enrollment increase was approximately 40 per cent, bringing the total to nearly the 4,000,000 mark. Reports coming in now indicate that enrollment will reach 5,000,000 by early 1947.

Even more encouraging, however, is the indication that a number of the plans servicing heavily populated areas have recently begun to get into full swing in their enrollment program. While it is essential that plans be available to all people in all areas, it is even more essential at present that the enrollment in the populous cities and states begin to catch up with that of the Blue Cross plans.

It is hoped that any lessening of the urge for compulsory sickness insurance on the part of Congress will not slow efforts of the profession in developing and expanding these plans. Indeed some sort of legislation possibly may be introduced that will encourage the creation of voluntary health insurance plans, perhaps providing for the use of Government funds to help carry insurance in the various local plans for those who could not afford to pay for this coverage themselves.

An over-all factual presentation of the voluntary health insurance picture is long overdue, even though the picture is changing so fast that any contemporary comment is likely to be outdated by the time it is published. Much has been said and written advocating some special type of plan—as if it were the entire answer. Attempts to oversimplify the problem have sometimes only complicated the question for those who are not students of insurance.

The problem is still further complicated by philosophic background and ardent beliefs of the various groups such as:

Those who believe the answer lies alone in service plans;

Those who believe indemnity plans are the answer to the problem;

Those who feel that private insurance companies should do the job and that medicine should not get into the insurance business;

And finally those who don't want to do anything different from what's been done in the past.

Add to these complications the questions as to what the exact relationships should be with Blue Cross, all superimposed on the burning question as to whether or not the Associated Medical Care Plans, the inter-plan organization of non-profit plans, should admit into membership state and local plans operated by private insurance carriers.

Is there any wonder, therefore, that the average busy doctor is more or less confused and sometimes tempted to say, "I should worry, it's all too complicated." That, of course, is most unfortunate for it's going to take the active interest and wholehearted support of all to do the job.

And that's where the Council on Medical Service comes in, to present the facts in regard to advantages and disadvantages of the various plans, keep records up to date on all new developments in the medical care field, conciliate differences of opinion as to the various forms of insurance—in short, view the entire question impartially and objectively, in order to do everything possible to encourage the wholehearted acceptance by every state society of a practical, workable plan.

The whole insurance program is still experimental. No one knows the complete answer. Hence, the Council hopes to encourage all types of plans that meet the minimum requirements set by the Council to maintain the standard of medical service for the protection of the public.

Here's the way the Council is set up to do the job of (1) encouraging development of new plans; (2) keeping the profession informed as to developments; (3) helping to increase the enrollment of plans already established.

A Prepayment Division of the Council has been created with George Cooley, Assistant Secretary of the Council, keeping in contact with Medical Society-sponsored plans; Howard Brower, maintaining contact with the private insurance groups; and L. S. Kleinschmidt, concentrating his efforts on encouraging rural enrollment and maintaining contact with the newly created Consumer-Cooperative movement.

Prepayment plans have progressed rapidly in the cities, but development in the rural areas has been slow, although several plans have been making notable advancements along this line.

Jay Ketchum, Executive Vice President of Michigan Medical Service, is acting as consultant for the Council.

Within the past few months private insurance carriers are showing an intense interest in medical and surgical care coverage and, as a result, there have been many conferences both formal and informal. A joint conference was held with representatives of large insurance associations in Chicago in September, with Dr. E. J. McCormick, of Toledo, Chairman of the Council, presiding. This conference was unusual as it brought together officials of large insurance associations. The appointment of two joint subcommittees, composed of representatives of the insurance groups and medicine, have been created: the first one, Subcommittee on Coöperation, with Dr. A. W. Adson, of Rochester, serving as Chairman; the second, Subcommittee on Rural Enrollment, with Dr. James R. McVay, of Kansas City, as Chairman. Blue Cross and the Associated Medical Care Plans are also represented on these subcommittees. The subcommittees held meetings in New York in November and reports of these committees should be ready for consideration of the House of Delegates at the December meeting on this phase of the problem.

One of the most important developments has been the creation of Associated Medical Care Plans, with Dr. H. L. Schriver, of Ohio, as President; William M. Bowman, California, Vice President; Jay Ketchum, Michigan, Secretary; and Dr. Norman Scott, of New Jersey, Treasurer. In a sense this is a trade organization of plans. It can be of great service in developing reciprocity, details of selling, coöperative actions and procedures. Frank Smith, who has served with the California Physicians' Service as Director of Public Relations, recently has been appointed A.M.C.P. director. Although A.M.C.P. will be housed with the Council and its work integrated with the work of the Council and in accord with the policies of the Council, it is a legal entity separate and distinct from the Council. The Board of Trustees has allotted through the Council sufficient funds to this organization to get started.

The Council is also aided by Dr. Frank Dickinson, director of the Bureau of Medical Economic Research of the American Medical Association, and T. V. McDavitt of the AMA staff has served as the legal advisor of A.M.C.P.

Any consideration of the problem would not be complete without considering the following two important new developments in the over-all medical care field in general and the prepayment field in particular:

First, the Coöperative Health Federation of America composed of Consumer Coöperatives as contrasted with the Medical Society-sponsored prepayment plans. The Council is undertaking an objective study of these organizations offering

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The Editors' Forum

WHAT ABOUT GENERAL PRACTICE?

WINGATE M. JOHNSON, M.D.
Editor, North Carolina Medical Journal

EDITOR'S NOTE: This is the first in a series of articles by editors of state medical journals. In extending an invitation to editors to contribute to the Forum, the Editorial Board of the MEDICAL ANNALS requested that contributions have some bearing on the future of medicine—scientifically, economically and socially. The Board feels certain that readers will find these articles both instructive and enjoyable.

Dr. Johnson, the first contributor, is nationally known not only for his medical writings but also for his contributions to the best lay publications. His choice as first contributor to this department is therefore a most happy one.

Dr. Johnson will be followed by Dr. Stanley B. Weld, Editor of the Connecticut State Medical Journal, Dr. Robert N. Nye, Managing Editor of the New England Journal of Medicine, Dr. Julian P. Price, Editor of the South Carolina Medical Journal, and Mr. C. H. Crownhart, Managing Editor of the Wisconsin Medical Journal.

Many years ago the late Dr. D. N. Dalton told the story on himself that a newcomer to Winston-Salem once sent for him because he was "the only common doctor there is left." She had called a number of doctors listed in the telephone book, only to be told by one after the other that his work was limited to a certain specialty. She was overjoyed when a neighbor told her that Dr. Dalton was able to treat the whole body.

Today this woman would have an even harder time finding a family doctor, for the proportion of specialists in the medical population has increased considerably. One of the most pressing problems before organized medicine today is that of maintaining enough "common doctors" to treat the common ailments, which constitute 85 per cent of medical practice. The multiplication of articles dealing with this subject indicates the keen interest being taken in the preservation of the family doctor. It is recognized by most medical men, even by the specialists, that he is essential to the medical scheme; yet only too little constructive and concerted effort has been made to encourage young men to go into general practice. The overwhelming majority of recent graduates are planning to specialize. Before doing so, these young men should face a few facts soberly.

First, they should remember that it has been shown that 85 per cent of human ills can be cared for by a competent family doctor. This leaves 15 per cent to be divided among the specialists. So long as our pseudo-prosperity lasts, the specialists will get more than their share of work. During the depression which will inevitably follow, however, the general practitioner will again come into his own.

Second, the young doctor should realize that there are some highly specialized branches of medicine which may cease to be lucrative. The time was when a few men earned large incomes by giving transfusions; now interns, medical students, and even hospital corpsmen have taken over this procedure. Once the treatment of syphilis yielded handsome dividends; now this disease, which formerly meant weekly visits to the doctor's office for periods of months or even years, can be adequately treated in a matter of days. Even pediatrics is losing many of its financial rewards: One after another of the childhood diseases is being conquered by immunization; infant feeding has become so simplified and standardized that there is little to it; dysentery is now almost unknown, and the second summer has long ago lost its dread. It is no wonder that a few years ago the American Academy of Pediatrics solemnly passed a resolution to raise the age limit of pediatric patients to 18 years.

The principle of diversified crops may have some application in medicine, as in farming. If one field of practice becomes unproductive, the family doctor can depend on a livelihood from the others which he has cultivated.

A third consideration for the young graduate is that the attractions of general practice will almost certainly be enhanced as a result of the Hill-Burton bill. This bill should greatly increase the number of hospitals located in smaller towns and in thickly settled rural communities, where the general practitioner can have access to their facilities for diagnosis and treatment. It is quite probable that in a number of these hospitals office space will be provided for men who want to enjoy the benefits of group practice without giving up the rewards that are peculiarly a family doctor's.

These rewards, intangible though they are, should be the first and greatest consideration of a young doctor who is contemplating family practice. In no other field of medicine is there a greater opportunity to serve humanity and to make full use of all the talents one possesses. The families of a general practitioner are his friends, not merely his patients. The "common doctor" is rewarded for his services, not with money alone, but with the loyalty and love of those whom he serves.

DISTRICT OF COLUMBIA FIRST TO COMPLETE CHILD HEALTH STUDY

To the District of Columbia Study program goes the honor of having been the first to complete the collection of its share of the data for the nationwide Study of Child Health Services. Under the able direction of Dr. Edgar P. Copeland, Academy Chairman for the District, and Miss Barre Pritchett, Executive Secretary, the task of assembling detailed information from physicians and dentists in private practice, public and voluntary health agencies, and all hospitals and related institutions in the District concerning their facilities and services for children, has been accomplished.

The many schedules completed by professional personnel and health organizations within the District are now in the Central Office of the Study ready for statistical processing. It is expected that the tabular material prepared by the main office from the schedules will be returned to Dr. Copeland and his associates in the Study for the preparation of an over-all report for the District within the next six months.

The final report on returns for the District indicates the following percentages for the various groups represented in the Study:

Group	*Per cent Returns*
Pediatricians	100
Physicians	71
Dentists	51
Official and Voluntary Health Agencies	100
Hospitals and Other Institutions	100

Members of the Study Committee, which was formed in early April to assist Dr. Copeland in the conduct of the Study, have been active throughout the project in helping to collect the necessary information. To Dr. Joseph S. Wall, Dr. Ethe Dunham, Dr. P. A. McLendon, Dr. William S Anderson, and Dr. William A. Howard goes much of the credit for a task well done. Space does not permit full acknowledgment of the credit due the 26 members of the Advisory Committee for their part in supporting the Study. Special mention should be made, however, of the generous financial contribution of the Washington Chapter of the National Foundation for Infantile Paralysis, and those of the Fellows of the District Academy of Pediatrics, and a local commercial firm. Further expressions of appreciation will be left to the District Study report.

In summarizing the progress and achievements of the District Study program at the meeting at the Mayflower Hotel, September 30 and October 1, Dr. Copeland stated:

"Approval and endorsement of the Study of Child Health Services in the District of Columbia has been virtually unanimous. An attitude of interested concern has been exhibited by those participating in the Study, indicating a real desire to learn of the needs of the community concerning medical care for children and an earnest wish to meet those needs in providing an adequate program for all children.

"The general consensus of opinion is that data collected in the Academy Study should be made available in concrete and usable form to those responsible for future planning; this information to be released as early as possible and presented to the community in such a fashion as to inform the public of existing needs and to arouse a consequent interest in meeting those needs.

"Organizations and individuals who have participated in the District program feel that an excellent picture of child care facilities can be formed from the data collected. An evaluation of the strong and weak points of each community can be drawn, placing the emphasis on strengthening the weak spots. The use to which the material made available by the Study is put will determine the ultimate success of the whole undertaking. Impetus for planning depends on knowing what already exists and where improvements are needed. The Study can provide this impetus by releasing the information through the proper channels to the responsible groups."

RACHEL E. SPINNEY
Assistant to the Director,
Study of Child Health Services,
American Academy of Pediatrics

LASKER AWARDS FOR 1946

In the hope of increasing professional and public interest in medical research and public health administration, the American Public Health Association and the Albert and Mary Lasker Foundation have coöperated in giving a series of awards to dramatize the importance of work already done.

The first series of awards, presented to the Association by the Foundation, for advances made during the past five years, were given on November 12 at the 74th Annual Meeting of the American Public Health Association in Cleveland. They will be awarded annually hereafter.

Five individual awards of $1,000 each were offered, together with a gold statuette of the Winged Victory of Samothrace, symbolizing a victory in the fight against disease and death.

Because some important discoveries in medicine in the past few years were not the work of a single man, but of large groups of men and women working together against time to solve a specific problem, the Committee decided to add five group awards to the originally planned individual awards. These awards were in the form of a citation and a Winged Victory statuette in silver presented to the administrative leader of the group. Following are the five groups which were selected for these awards:

The Bureau of Entomology and Plant Quarantine of the U. S. Department of Agriculture, for its work in controlling insect-borne diseases, and particularly for its research on DDT.

The Army Epidemiological Board, for its work in the control of infectious diseases, one aspect of which was its development of an effective vaccine against influenza.

The National Institute of Health, U. S. Public Health Service, for its work during the war in the fields of dysentery, malaria and typhus.

The Northern Regional Research Laboratory of the Department of Agriculture, for studies leading to the mass production of penicillin.

The Board for the Coördination of Malarial Studies, for its work leading to the development of new and effective agents for the prevention of malaria. This Board, formed in December 1943, and composed of representatives of the Army, Navy, Public Health Service, National Research Council, Committee on Medical Research and civilians engaged in malaria research, is an outstanding example of the fusion of effort of several different agencies, brought about by wartime necessity.

The individual award winners and, briefly, the accomplishments for which the awards were presented follow:

Dr. Carl Ferdinand Cori, of Washington University School of Medicine, St. Louis, Mo., who has provided the first real clue as to how insulin permits the body of a person sick with diabetes to burn sugar.

Dr. John Friend Mahoney, a senior surgeon with the U. S. Public Health Service, stationed at the U. S. Marine Hospital, Staten Island, New York, for research into the penicillin treatment of syphilis.

The third Lasker award was presented jointly to the three men responsible for the discovery of the Rh factor. The late Dr. Karl Landsteiner, whose award was accepted by his son, Ernest, won the Nobel prize and the Paul Ehrlich medal in 1930, as well as the Dutch Red Cross medal in 1933, because of the discovery of blood groups. The second joint winner was Dr. Philip Levine, a graduate of the Cornell School of Medicine in New York City. Dr. Levine now lives in Plainfield, N. J., and is the director of the biologic division of a commercial organization. The youngest of the trio, Dr. Alexander S. Wiener, is a native of Brooklyn and a well known contributor to scientific and medical journals

Dr. Alfred Newton Richards, Professor of Pharmacology at the University of Pennsylvania, received the fourth award for his work during World War II as Chairman of the Committee on Medical Research of the U. S. Government's Office of Scientific Research and Development.

Dr. Fred L. Soper, Associate Director of the International Health Division of the Rockefeller Foundation, fifth award, for his successful fight against malaria and yellow fever.

The Lasker Awards Committee, under the chairmanship of Dr. George Baehr, President of the New York Academy of Medicine, is composed of nine of the Nation's foremost leaders of medical science and health. Serving with Dr. Baehr are Dr. Thomas Francis, Professor of Epidemiology, School of Public Health, University of Michigan; Dr. Hugh R. Leavell, Professor of Public Health Administration, Harvard University School of Public Health; Dr. Robert F. Leeb, Professor of Medicine, College of Physicians and Surgeons, Columbia University; Dr. Karl F. Meyer, Director, G. W. Hooper Foundation, University of California Medical Center; Dr. Thomas Parran, Surgeon General of the U. S. Public Health Service; Dr. Alfred N. Richards, Professor of Pharmacology, University of Pennsylvania; Dr. Ernest L. Stebbins, Director, Johns Hopkins University School of Hygiene and Public Health; and Dr. James S. Simmons, Dean, Harvard University School of Public Health.

MEETINGS

Wednesday, January 15

The program will be presented by the *Washington Urological Society*. Speakers and subjects to be announced.

Wednesday, January 29

The District of Columbia Pharmaceutical Association will sponsor the program. Speakers and subjects to be announced.

NATIONAL HEART WEEK

"In a broad effort to retard the rapid increase of heart disease throughout the Nation" the American Heart Association has initiated a nationwide program of public education and information on diseases of the heart. According to Dr. Howard F. West, of Los Angeles, President of the Association, fatalities ascribed to diseases of the heart are greater than the total of the next five leading causes of death, i.e., cancer, accidental deaths, nephritis, pneumonia and tuberculosis.

It is estimated that there are more than 4,000,000 people in the United States today who have heart disease. Diseases of the heart and blood vessels, including cerebral hemorrhage, accounted for 575,000 deaths in 1944, as compared to 477,000 deaths from the next five leading causes. According to recent surveys, rheumatic fever and heart disease in children causes more than five times as many deaths as the combined total of deaths from infantile paralysis, scarlet fever, diphtheria, measles, meningitis and whooping cough. It is also a serious disease among adults; 40,000 veterans acquired the disease during their recent military service.

An estimated 10 per cent of the men rejected by Selective Service were disqualified because of cardiovascular diseases. In a special sampling of 5,000 rejectees for cardiovascular diseases in five major cities, 50 per cent were disqualified because of rheumatic heart disease, while 25.6 per cent were disqualified because of hypertension.

National Heart Week will begin on February 9, 1947, the educational campaign to reach its climax during that week. The public will be apprised of the significance of blood pressure, infections, overweight, rheumatic fever, and other factors which contribute to various types of heart disease. The program will also call for emphasis on educational work with schools, parent-teachers associations, and other groups concerned with children.

Among the coöperating groups will be the American Medical Association, the American College of Physicians, the American Academy of Pediatrics and the American Rheumatism Association. The local Heart Association and affiliated groups will assist in the national campaign. Dr. Wallace M. Yater is the local Director of the American Heart Association.

MEMBERSHIP

The following applicants for Active membership will be voted on at the meeting of the Executive Board, January 27, 1947:

Frederick J. Balsam, Lausanne University, Swtz.—1938
Edwin Edmunds Barksdale, University of Virginia—1933
Robert A. Cohen, University of Chicago—1935
Joseph Wilkins Cooch, Jefferson Medical College—1934
Allen M. Ferry, Johns Hopkins University—1938
Joseph N. Hamm, George Washington University—1942
William Louis Harris, Georgetown University—1942
Irwin Herbert Kaiser, Johns Hopkins University—1942
Lawrence C. Kolb, Johns Hopkins University—1934
Lloyd G. Lewis, Johns Hopkins University—1928
Paul A. Manganaro, University of Siena, Italy—1936
John A. Mitchell, University of California—1942
Wendell A. Parker, St. Louis University—1936
Monroe James Romansky, University of Rochester—1937
Roy Clayton Rounds, University of Wisconsin—1938
Leon Salzman, Royal College of Physicians and Surgeons, Glasgow, Scotland—1940
Louis Harry Shuman, University of Maryland—1942
James Alexander Smart, George Washington University—1919
Oliver E. Thompson, College of Medical Evangelists—1925
Valentine Anthony Ujhely, Royal University, Budapest, Hungary—1920

Recent changes in membership status:

Active to Associate

Frederick Y. Donn, Jr.
Wilkins R. Manning
Charles A. Schutz

Associate reinstated to Active

Max E. Feldman

Reinstated to Membership
Active

Louis S. London
S. Logan Owens

Associate

David E. Buckingham
James P. Leake

Resigned
Active

Edmund Horgan
Stephen E. Kramer
James M. Suter

Associate

Olive Pippy
W. C. Welburn

BOOK REVIEW

Diabetes—A Concise Presentation. Henry J. John, M.A., M.D., F.A.C.P., Lieutenant Colonel, Medical Corps, Cleveland, Ohio. Pp. 300, illustrated. Price, $3.25. St. Louis: Mosby, 1946.

This volume, intermediate in scope between the manuals for patients and the exhaustive treatises, presents an up-to-date discussion of the problems concerning diabetic patients. It deals with these problems from the viewpoint of practical management of patients.

The author is an acknowledged expert in the specialty of diabetes. In his years of private practice and service in the Army Medical Corps he followed the practice of requiring his diabetic patients to be closely controlled by frequent blood sugar determinations. By constructing graphic curves of fluctuations in blood sugar levels during the day and night, he has been able to control his patients more precisely than is possible with observations on only the fasting blood sugar and urinary sugar excretions. He is a believer in the immediate and long range benefits expected from keeping a patient's chemical condition controlled constantly in as nearly normal a way as possible. Although this procedure requires more laborious study it saves hospitalization time in the end.

Blood sugar curves are frequently presented and increase the clarity of his text. In addition to discussing general problems in treatment, diagnosis, and prevention of diabetes and diabetic coma, chapters are devoted to such problems arising in surgery, obstetrics and pediatrics.

A practical discussion of diet in diabetes is given with unique diagrams presenting graphically the fractional values of common foods. The chapter on "Do's and Don'ts" should be of value to anyone dealing with diabetic patients. Chapters on hyperinsulinism, hyperthyroidism and hemochromatosis are clearly presented.

This volume is a useful contribution to the literature on diabetes for readers who lack time for extensive reading in the field. The style of writing, aside from occasional structural errors, and the size of the book make reading enjoyable.

The author campaigns vigorously for three issues: (1) obesity is inexcusable; (2) blood sugar levels should be kept normal at all times; (3) summer camps for diabetic children should become more widespread.

Joseph T. Roberts, M.D.

Washington Physicians of Yesterday

NOBLE YOUNG, A.M., M.D.

Dr. Noble Young was born June 26, 1808, in Baltimore, Maryland. He graduated in medicine from the Columbian Medical School in 1828, after which for the remainder of his life he practiced medicine in Washington, where he became an outstanding and forceful member of the profession and the community. He was very active in the affairs of the local medical organizations, rendering much service in official capacities, and becoming President of the District Medical Association, 1868–70. He was also Vice President of the American Medical Association in 1869.

Dr. Young was one of four who organized the Georgetown Medical School in 1851, and he served the School as Dean and Professor of Medicine until 1876. Although cultivated, polished, and genial to his friends, he was a man of positive and uncompromising opinions. In his day the formation of medical schools was in general frequently attended with bitter dissensions and jealousy, the partisans of rival schools assailing one another with vitriolic vituperation, and even personal assaults and dueling. The formation of the Georgetown Medical School in Washington was no exception; and for many years thereafter the local medical profession was in a ferment of passion, sharply divided into two bitterly hostile factions.

Dr. Young was married May 6, 1836; he died April 11, 1883, at Sacketts Harbor, New York.

John B. Nichols, M.D.

News and Personals

The American Medical Association is making elaborate plans for its centennial celebration in Atlantic City, N. J., June 9–13, 1947, to which only Fellows and invited guests are eligible to attend. Membership in the District or a state society is the primary qualification for Fellowship in the AMA. Those who are not Fellows and plan to attend the Atlantic City session should write now to the American Medical Association, 535 North Dearborn Street, Chicago 10, and ascertain their eligibility for Fellowship.

The Forty-Third Annual Congress on Medical Education and Licensure will be held on February 10 and 11, 1947, at the Palmer House, Chicago. Hotel reservations should be made immediately and should be addressed to Mr. Frank Anton, Council on Medical Education and Hospitals, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

The Department of Ophthalmology of the George Washington University School of Medicine is planning to resume the **William Thornwall Davis Intensive Postgraduate Course in Ophthalmology** which has been given annually except during the War. The next course is scheduled for February 3–8, 1947, Monday through Saturday, from 8:30 a.m. to 5:00 p.m. Subjects of clinical interest to the practicing physician doing eye work will be presented.

The following guest lecturers will participate: Dr. F. Heed Adler, Philadelphia; Dr. J. Mason Baird, Atlanta; Dr. S. Judd Beach, Portland, Me.; Dr. Hermann M. Burian, Boston; Dr. Ramon Castroviejo, New York City; Dr. C. Alvin Clapp, Baltimore; Dr. F. Bruce Fralick, Ann Arbor, Michigan; Dr. Deane B. Judd, Washington, D. C.; Dr. Peter C. Kronfeld, Chicago; Dr. Walter I. Lillie, Philadelphia; Dr. Angus L. MacLean, Baltimore; Mr. Philip L. Salvatori, New York City; Dr. Harold G. Scheie, Philadelphia; Dr. Edmund B. Spaeth, Philadelphia; and Dr. Frederick W. Stocker, Durham, N. C.

CALENDAR OF MEETINGS

November 5	Committee on Public Health
November 6	Program Committee
November 7	Section on Neurology and Psychiatry
November 12	Committee on Arrangements, Annual Scientific Assembly
November 13	Scientific Meeting of Society
November 18	Grievance Committee
November 20	Scientific Meeting of Society
November 22	Committee on Radio Education
November 25	Executive Board Board of Censors
November 26	Committee on Special Events

The Tenth Annual Postgraduate Course in Ocular Surgery, Pathology and Orthoptics will be presented during the week of January 27–February 1, 1947. The Army Institute of Pathology will provide the instruction in pathology under the direction of Colonel J. E. Ash. Assisting him will be Mrs. Helenor Campbell Wilder and Lawrence P. Ambrogi, of the Army Institute of Pathology, and Dr. M. Noel Stow, Dr. Arnold W. Forest and Miss Eleanor Paul. The surgery demonstrations will be given by the faculty of the Department of Ophthalmology of George Washington University School of Medicine under the direction of Dr. Ernest Sheppard, Professor of Ophthalmology. This is a practical course with demonstrations on animal eyes. The course will be limited to 30 applicants.

For further details regarding either of the above courses, write to the Secretary, Miss Mary E. Kramer, Suite 34, 1801 K Street, N.W., Washington 6, D. C.

The Tri-City Meeting of the Sections on Neurology and Psychiatry of Philadelphia, Baltimore and Washington will be held January 10, 1947, at 4 p.m., at the Mayflower Hotel. The following program will be presented: "Psychosomatic Reactions and the Psychoneurosis," Dom Thomas Verner Moore, Professor of Psychology and Psychiatry, Catholic University; "Spasticity—Its Connotation and Its Treatment," Dr. Vasilios S. Lambros, Instructor in Neurological Surgery, George Washington University School of Medicine; "Relationship of Neurology to Psychiatry," Dr. David McK. Rioch, Director of Research, Chestnut Lodge Sanitarium, Rockville, Md. The discussors will be provided by Baltimore and Philadelphia.

Reservations for the dinner, which will follow the meeting, should be made with Dr. Lambros, 1029 Vermont Avenue, N.W., before January 3, 1947.

The Silver Spring Academy of Medicine has invited Dr. Neil W. Swinton, surgeon on the staff of the Lahey Clinic, to be its guest speaker, January 6, 1947. He will speak on "Carcinoma of the Colon and Rectum." His paper will be discussed by Drs. Garnet W. Ault and Robert J. Coffey. Members of the Medical Society are invited to attend.

The Georgetown University Medical Center will sponsor an intensive graduate course in Otorhinolaryngology and Bronchoscopy at Georgetown University School of Medicine, for a two-week period beginning April 7, 1947. The lecturer will be Professor Georges Portmann of the University of Bordeaux, France. Inquiries should be addressed to Dr. James A. Flynn, 1511 Rhode Island Avenue, N.W., who was responsible for obtaining the speaker.

The American Urological Association offers its annual urology award "not to exceed $500" for an essay (or essays) on the result of some clinical or laboratory research in urology. Competition is limited to urologists who have been in such specific practice for not more than 5 years and to residents in urology in recognized hospitals. Full particulars can be secured by writing to the Secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tenn. Manuscripts must be in his hands before May 1, 1947.

The selected essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Hotel Statler, Buffalo, New York, June 30–July 3, 1947.

The National Gastroenterological Association announces its annual award for 1947 of $100 and a Certificate of Merit for the best unpublished contribution on gastroenterology or allied subjects. Certificates will also be awarded those physicians whose contributions are deemed worthy. The award will be made at the annual convention banquet of the National Gastroenterological Association in June of 1947.

Contestants residing in the United States must be members of the American Medical Association. The manuscript must be limited to 5,000 words, typewritten, submitted in five copies, and mailed so as to reach the National Gastroenterological Association, 1819 Broadway, New York 23, N. Y., not later than April 1, 1947. The Association reserves the right of publishing the winning contribution, and those receiving certificates of merit, in its official publication, *The Review of Gastroenterology.*

The Board of Trustees of MEDICAL SERVICE OF THE DISTRICT OF COLUMBIA held its first meeting, October 29, in the Medical Society's building. Following adoption of by-laws, the following officers were elected: Dr. Frank D. Costenbader, President; Dr. W. Warren Sager, First Vice President; Dr. G. Halsey Hunt (USPHS), Second Vice President; Theodore Wiprud, Secretary; Howard Strong (U. S. Chamber of Commerce), Treasurer.

The following members of the Medical Society have recently returned to civilian practice after serving in the armed forces:

George David Adams, c/o General Delivery, BA 4, Mt. Vernon, Ohio
Harold Y. Finck, 1435 Good Hope Road, S.E.
Luther A. Gilliom, Garfield Hospital
Nicholas G. Pistolas, Children's Hospital
Alfred J. Suraci, 1835 Eye Street, N.W.
Joseph R. Young, 1400 M Street, N.W.

Drs. George A. Resta, Suraci and Young terminated their Army service with the commission of Lieutenant Colonel. Dr. Resta's name appeared on an earlier list of returned medical officers.

The Section on Neurology and Psychiatry presented a symposium on "A Postwar Program for Psychiatry and Neurology" on November 7. Discussion was led by Drs. Norman Q. Brill and Z. M. Lebensohn.

Guest speaker at the **Washington Opthalmological Society**, November 4, was Professor W. J. B. Riddell of the University of Glasgow, Scotland; his subject, "Clinical Valuation of Cataract Operation." This was a joint meeting with the Baltimore Ophthalmological Society. Case presentations were made by Drs. Jerome A. Sansoucy and Edward J. Cummings.

Dr. Bernard W. Leonard was host to the **Clinico-Pathological Society**, November 19, at his home. Two papers were presented at this meeting: "Unusual Forms of Exophthalmos in Thyroid Disease," Dr. Lewis C. Ecker; "Some Vascular Accidents," Dr. Janvier W. Lindsay.

The George Washington University Medical Society held its first fall meeting for 1946–47 on October 19. Dr. John A. Kolmer, Professor of Medicine at Temple University, Philadelphia, was guest speaker. His address was entitled, "The Pharmacology and Therapeutic Applications of Streptomycin Therapy."

The second meeting of the Society was held on November 16. The program consisted of a Panel Discussion on Acute Respiratory Diseases—The Pneumonias. The subject matter was presented in three parts by the following speakers: Etiology and Pathology, Dr. Roger M. Choisser; Radiological Findings, Dr. Arthur C. Christie; Diagnosis and Treatment, Dr. Harry F. Dowling. Drs. Clayton B. Ethridge and Russell K. Hollingsworth led the discussion, the former from the viewpoint of internal medicine and the latter from the viewpoint of surgical complications.

The Metropolitan Washington Tuberculosis Conference convened for its second annual meeting, October 24, at Gallinger Municipal Hospital. Drs. Brian B. Blades and Edgar W. Davis conducted a clinic on "Surgical Therapy in Thoracic Diseases" at one of the sectional meetings held during the morning.

Dr. Monroe J. Romansky, from the staff of Walter Reed Hospital, gave the principal address at the afternoon session. His subject was "The Present Status of Streptomycin in Tuberculosis." Dr. Alvin R. Sweeney, Superintendent of Gallinger Hospital, extended greetings. Presiding was Dr. Daniel L. Finucane.

Dr. John Sims, Alexandria, was elected President for 1947. Other officers elected were Dr. LeRoy R. Allen, Chief of the Bureau of Tuberculosis, Maryland State Health Department, Vice President, and Miss Rebecca Sweeney, Secretary. Miss Sweeney is Director of Information of the District Tuberculosis Association.

The National Cancer Institute, which operates as a division of the National Institute of Health, has funds to train approximately 30 physicians in the diagnosis and treatment of cancer, according to an announcement made by Dr. Thomas Parran, Surgeon General of the U. S. Public Health Service. Under a federally financed program, doctors wishing to specialize in this field may be appointed as trainees and assigned to authorized non-federal, non-profit institutions in various parts of the country.

A Memorial Laboratory for the study of infectious diseases, the eighth building of the National Institute of Health at Bethesda, Md., was officially dedicated on October 27 at a ceremony attended by medical and civilian dignitaries of the United States, Russia and China. The Laboratory will memorialize 23 members of the U. S. Public Health Service who "died in the line of duty." Dr. Charles Armstrong, Chief of the Division of Infectious Diseases, National Institute of Health, will administer the Laboratory. The building has been carefully planned and constructed to provide maximum safety for the scientists who will carry on the dangerous work that already has taken so many lives. Several of the unique preventive facilities incorporated in the new Laboratory are a result of Dr. Armstrong's experiences, who has several times been the victim of disease in the course of his work in research.

Dr. James A. Crabtree, Deputy Surgeon General of the U. S. Public Health Service, spoke for Surgeon General Thomas Parran, who was unable to be present. Dr. Vassily V. Parin, Secretary General of the Academy of Medical Science of the U.S.S.R., and Dr. Szeming Sze, representing The National Health Administration of China, praised the project. Presiding at the ceremonies was Dr. Rolla E. Dyer, Director of the National Institute of Health.

In order to help meet the nursing shortage, **Doctors Hospital** is offering a free course in practical nursing for nurses' aides. Fifteen young women between the ages of 18 and 35 enrolled for the first course, October 15.

The course will require one year to complete, the time to be allocated as follows: first 4 months, preclinical work; next 7 months to be spent on the floors; the last month, review and five hours daily in selected departments. The subjects to be studied are Anatomy, Physiology and Hygiene; Physical Care; Hospital and Home Nursing Procedures; Care of Infants and Young Children; Housekeeping; Dietetics; Nutrition, etc. Students will be paid $50 per month while training; meals, books and uniforms furnished gratis. A certificate will be presented each student who finishes the course; graduates may find employment through the Hospital registry. Applications are now being accepted from women wishing to enroll in the February class.

The Woman's Auxiliary to the Medical Society of the District of Columbia honored the wives of doctors who have returned from the armed services at a tea held in the Society's Library, November 13. In the receiving line were Mrs. William P. Herbst, Jr., President of the Auxiliary, Mrs. A. Barnes Hooe, Mrs. Richard H. Todd, and Mrs. Leo C. Varden. Presiding at the tea table were Past Presidents of the Auxiliary.

Frank G. Dickinson, Ph.D., has been appointed Economist and Director of the **Bureau of Medical Economic Research of the American Medical Association.** Dr. Dickinson resigned his position at the University of Illinois as Associate Professor of Economics in order to accept the appointment. He was President of the American Association of University Teachers of Insurance during 1944 and 1945, its Secretary-Treasurer from 1932 to 1937, and was one of the joint authors of the Preliminary Draft of the Illinois Insurance Code in 1934–35. He is particularly well known for the Dickinson Football Ratings and the Rockne Memorial Trophy, sponsored by the Famous Four Horsemen, which he permanently awarded to the University of Minnesota in 1940.

Dr. Dickinson succeeds Dr. R. G. Leland, retired, who had served as Director of the Bureau of Medical Economics of the AMA since it was established in 1931.

The appointment of 122 additional **civilian medical consultants to the Secretary of War,** through the Surgeon General, has just been announced by the War Department, bringing the total of civilian consultants available to the Army Medical Department to 327. Physicians appointed locally were previously recorded on page 518 of the October issue of the ANNALS. The new list includes the following appointees from Washington together with their special fields:

Pediatrics—Dr. John A. Washington
Obstetrics and Gynecology—Dr. Carlton N. Price
Psychiatry—Dr. Seymour Rosenberg
Bacteriology—Dr. George G. Callender

At an informal tea at Children's Hospital, October 27, associates and friends of **Dr. Joseph S. Wall and Dr. Edgar P. Copeland** gathered to observe their anniversary month. Dr. Wall, Chairman of the medical staff, had completed fifty years of service at the Hospital and Dr. Copeland, Vice Chairman of the staff, more than 47 years.

The tea was sponsored by the Board of Lady Visitors. Invitations were limited to the Board members, the Board of Directors of the Hospital, members of the Children's Hospital Child Welfare Society, heads of the Hospital departments, and their respective husbands and wives. As many of the nurses and members of the resident staff as could leave their duties were present.

There was no formal program to mark the occasion, but among those who paid affectionate tribute to these "deans of medicine" were Mr. Thomas Bell Sweeney, Vice President of the Board of Directors, who spoke in behalf of the Board since the President, Mr. Charles D. Drayton, was out of the city; Mrs. William Chapin Huntington, President of the Board of Lady Visitors; Dr. Preston

A. McLendon, of the medical staff; Miss Mattie Gibson, Superintendent of the Hospital; and Miss Ashby Taylor, Superintendent of Nurses.

Mrs. Copeland was unable to attend because of illness, but Mrs. Wall was present to share honors with her husband. She also took a turn at the tea table during the afternoon.

Dr. Wall came to Children's Hospital as a resident student in 1896 and was followed three years later by Dr. Copeland. In those days four doctors comprised the entire staff. Courtesy staff privileges did not exist. Today there are 25 resident physicians and an entire medical staff of 400, which includes the consulting, attending, associate, junior and courtesy staffs. Nearly 8,000 cases a year are admitted to the institution, compared with 400 in 1896, while nearly 70,000 dispensary cases are treated each year, as compared with a few more than 3,000 in the early days. The annual budget in 1900 was $18,000, which amount would carry the Hospital only a week now.

Star Staff Photo

"DEANS OF MEDICINE" HONORED AT CHILDREN'S HOSPITAL

Mrs. William Chapin Huntington, President of the Board of Lady Visitors of Children's Hospital, Dr. Joseph S. Wall (right) and Dr. Edgar P. Copeland at a tea given in honor of Drs. Wall and Copeland on Octobe- 27.

Major General Norman T. Kirk, Surgeon General of the Army, was awarded the Cross of the Legion of Honor in the Degree of Commander, October 8, at the office of the French Military Attaché, Lt. General Maurice Mathenet. During the same ceremony **Brigadier General Raymond W. Bliss,** Deputy Surgeon General, received the Degree of Chevalier. Presentations were made by General Raymond Debenedetti, Surgeon General of the French Army.

Dr. Custis Lee Hall was chosen President-elect of the United States Chapter of the International College of Surgeons during its meeting in Detroit, October 21–23. He will take office in 1948. Dr. Hall is a former Vice President of the Medical Society of the District of Columbia, Past President of the Washington Medical and Surgical Society, and Past President of the George Washington University Medical Society. He is Clinical Professor of Surgery at George Washington University School of Medicine, his alma mater, where he has been a staff member for the past 26 years.

Dr. Walter A. Bloedorn, Dean of the George Washington University School of Medicine, was chosen President-elect of the Association of the American Medical Colleges at its 57th Annual Meeting in Edgewater Park, Mississippi. He was also selected to represent the Association on the National Commission for United Nations Educational, Scientific and Cultural Organization (UNESCO), and appointed chairman of the Association's committee on visual and auditory aids in medical education.

Dr. Thomas M. Peery, Director of Postgraduate Medical Education at George Washington University, was appointed to the Association's curriculum committee at the Mississippi meeting.

Dr. Samuel M. Dodek was elected a Fellow of the International College of Surgeons at the Detroit convention.

Several Washington physicians attended the meeting of the **Southern Medical Association** in Miami, Florida, November 4 to 7. **Dr. Oscar B. Hunter** was elected First Vice President of the Association. **Dr. Arnold McNitt** was elected to serve on the Executive Committee of the Council, which is made up of three members, one elected annually for a period of three years.

As Chairman of the Section on Pathology, Dr. Hunter gave the Chairman's Address. The subject of his paper was "Clinical Pathology as a Specialty in Medicine." **Dr. J. Ross Veal** discussed a paper on "Sympathectomy for Certain Forms of Peripheral Vascular Disease," and **Dr. William F. Burdick** discussed a paper on "Recent Advances in Pediatrics."

Dr. Emil J. C. Hildenbrand presented a film on "Surgery in Hypertension." Among the scientific exhibitors was **Dr. Jacob J. Weinstein.** The subject of his exhibit was "Protein Metabolism and Parenteral Protein Hydrolysate in Surgery."

Dr. Charles P. Cake presided at the X-ray Conference of the Southern Chapter of the American College of Chest Physicians. This Chapter meets conjointly with the S.M.A.

Dr. James A. Gannon is giving a series of radio talks on "Your Health" each Sunday at 3:15 p.m., over Station WOL. This program of health education for laymen has been endorsed by the Medical Society's Committee on Radio Education, of which committee Dr. Gannon is a member. Among the topics he has selected for discussion are: The Respiratory System, The Alimentary System, The Nervous System, The Skin, So You Are Forty Years Old, Appendicitis, Cancer, Tuberculosis, and Germs. In addition to questions and answers the programs will include occasional round table discussions.

Dr. Darrell Crain has been named one of the editors and co-authors of the Ninth Rheumatism Review. Before the War this was an annual summary of American and English literature on arthritis and rheumatic diseases. The present one will review the literature of 1941–1945, inclusive, and will be published in the *Annals of Internal Medicine* at an early date. Dr. Philip Hench of the Mayo Clinic is Editor-in-chief of reviews.

Drs. Russell H. Morgan and Herman E. Hilleboe were among the physicians of the United States who were invited to present scientific papers before the Second Inter-American Congress on Radiology, which met in Havana, Cuba, November 17–22. They presented a paper jointly on "Recent Developments in Mass Radiography in the United States."

Dr. Custis Lee Hall spoke on "Hip Fractures" at the Seventh Annual Meeting of the Ambulatory Fracture Association, Inc., which met in Galesburg, Illinois, November 14–16, 1946.

Dr. Lewis R. Thompson, Assistant Surgeon General in the Bureau of State Services, U. S. Public Health Service, retired November 1 after 36 years' service. He organized and formerly was director of the National Institute of Health. He was succeeded in office by **Dr. Herman E. Hilleboe,** who has been Chief of the Tuberculosis Division since 1944.

Dr. Frank D. Costenbader addressed members and guests of the District of Columbia Society for the Prevention of Blindness on "Eye Exercises" at its annual meeting and luncheon, November 19, at the Y.W.C.A. The occasion marked the tenth anniversary of the Society.

Theodore Wiprud was appointed to serve on the District Traffic Advisory Board for a term of two years, commencing July 1, 1946, by order of the Board of Commissioners. The Advisory Board in turn appointed him to serve on the Committee on Motor Vehicle Administration.

Dr. Emil J. C. Hildenbrand was appointed Medical Director of the Potomac Electric Power Company, effective October 1.

The District of Columbia Dental Society sponsored a Testimonial Dinner in honor of **Dr. Sterling V. Mead,** President of the American Dental Association. The dinner was held December 4 at the Statler Hotel. Dr. Mead is an Associate member of the District Medical Society.

Dr. Ella Oppenheimer addressed the first fall meeting of the Association of Parents of Cerebral Palsied Children, October 23, which met in the new quarters of the District Society for Crippled Children, 1767 Massachusetts Avenue, N.W.

Dr. Irma Belk-Hobart discussed "The Mental Health Commission" before the Women's Medical Society at its meeting in Doctors Hospital, November 5.

Dr. Alice H. Kiessling has been elected President of the **Fairfax County (Va.) Medical Association.** Other officers elected were Dr. William Meyer, Herndon, Vice President; Dr. T. B. McCord, Fairfax, Secretary; and Dr. Emanuel Newman, Vienna, Treasurer. Drs. Kiessling and Meyer are Associate Members of the District Medical Society.

REPRINTS RECEIVED

The following reprints have recently been received, for which due acknowledgement is made:

"Full-Time Public Health Positions in Local Health Departments." Marion E. Altenderfer. Public Health Reports, June 14, 1946.

"Time Per Service in a Children's Dental Clinic." Isidore Altman. Public Health Reports, August 16, 1946.

"Facts and Fallacies in the Integration of National Voluntary Health Agencies." D. B. Armstrong. The Journal of the American Medical Association, June 15, 1946.

"Complement Fixation in Tsutsugamushi Disease (Scrub Typhus)." Ida A. Bengtson. Public Health Reports, June 14, 1946.

"A Serological Study of 37 cases of Tsutsugamushi Disease (Scrub Typhus) Occurring in Burma and the Philippine Islands." Ida A. Bengtson. Public Health Reports, June 14, 1946.

"The Tropical Disease Education Program of the United States Public Health Service." William S. Boyd, Trawick H. Stubbs, and Paul P. Weinstein. Public Health Reports, May 17, 1946.

"Composition of Some Trade Name Solvents Used for Cleaning and Degreasing and for Thinning Paints." Allen D. Brandt, W. J. McConnell, and R. H. Flinn. Public Health Reports, February 1, 1946.

"Radiation Effects on the Human Stomach: A Preliminary Report." Irving B. Brick. The Review of Gastroenterology, September–October 1946.

"Influence of pH and Temperature on the Survival of Coliforms and Enteric Pathogens When Exposed to Chloramine." C. T. Butterfield and Elsie Wattie. Public Health Reports, February 8, 1946.

"A Day in the Office of a Psychiatrist." Frank S. Caprio. Medical Record, April 1946.

"The Incidence of Poliomyelitis and Its Crippling Effects, as Recorded in Family Surveys." Selwyn D. Collins. Public Health Reports, March 8, 1946.

"Diphtheria Incidence and Trends in Relation to Artificial Immunization with Some Comparative Data for Scarlet Fever." Selwyn D. Collins. Public Health Reports, February 15, 1946.

"Conclusions Concerning Psychiatric Training and Clinics. Meeting of Consultants in Mental Hygiene, USPHS, September 6, 1945." Public Health Reports, June 28, 1946.

"The Genera *Boophilus*, *Rhipicephalus*, and *Haemaphysalis* (Ixodidae) of the New World." R. A. Cooley. Washington: U. S. Government Printing Office, 1946.

"A Note on Physician Time Per Patient in Private Practice." Burnet M. Davis. Public Health Reports, September 21, 1945.

"Prevalence of Typhus Complement-Fixing Antibodies in Human Serums in San Antonio, Tex." David E. Davis and Morris Pollard. Public Health Reports, June 21, 1946.

"Complement-Fixation Tests for American Trypanosomiasis in Texas." Dorland J. Davis and Thelma deShazo Sullivan. Public Health Reports, July 19, 1946.

"Incidence of Poliomyelitis in the United States in 1945." C. C. Dauer. Public Health Reports, June 21, 1946.

"The Treatment of Trypanosomiasis with p-Arsenosophenylbutyric Acid. I. Results in 319 Cases of Early *Trypanosoma gambiense* Infections." Harry Eagle. Public Health Reports, July 12, 1946.

"Present Status of Diasone in the Treatment of Leprosy." G. H. Faget, R. C. Pogge, and F. A. Johansen. Public Health Reports, June 28, 1946.

"Promizole Treatment of Leprosy: A Preliminary Report." G. H. Faget, R. C. Pogge, and F. A. Johansen. Public Health Reports, June 28, 1946.

"The Public Health, the Politician, and the Doctor." Lowell S. Goin. Chicago: American College of Radiology, 1946.

"Negro Mortality. I. Mortality from All Causes in the Death Registration States." Mary Gover. Public Health Reports, February 22, 1946.

"*Plasmodium gallinaceum* Infection Characterized by Predominance of Exo-erythrocytic Forms." Victor H. Haas, Aimee Wilcox, Frances Park Davis, and Frances Moore Ewing. Public Health Reports, June 21, 1946.

"Studies of the Acute Diarrheal Diseases. XVII. The Sulfonamides in Shigellosis." Albert V. Hardy. Public Health Reports, June 14, 1946.

"Antibacterial Action of Penicillin, Penicillin X, and Streptomycin on *Hemophilus influenzae*." William L. Hewitt and Margaret Pittman. Public Health Reports, May 31, 1946.

"Electrocardiographic Alterations in Adult Rats as a Result of Acute Thiamine Deficiency." James M. Hundley and W. H. Sebrell. Public Health Reports, June 14, 1946.

"An Analysis of the Design and Performance of Airplane Exhaust Generators for the Production of DDT Aerosols for the Control of *Anopheles quadrimaculatus*." C. W. Krusé and R. L. Metcalf. Public Health Reports, August 9, 1946.

"A Performance Test for Rating Dishwashing Detergents." Edward H. Mann and C. C. Ruchhoft. Public Health Reports, June 14, 1946.

"Maternal Deaths Due to Infection," The Maternal Mortality Committee of the Committee on Maternal Health of the Minnesota State Medical Association. Minnesota Medicine, August 1945.

"A Public Health Program for Rural Areas." Frederick D. Mott. Public Health Reports, April 26, 1946.

"Training Public Health Workers." Joseph W. Mountin and Emily K. Hankla. Public Health Reports, May 24, 1946.

"The Notifiable Diseases; Prevalence of Certain Important Communicable Diseases, by States—1944." Public Health Reports, Supplement No. 190, 1946.

"The Effect of the Sodium Salts of Crystalline Penicillin G, Crystalline Penicillin X, and Commercial Penicillins on Darkfield Positive Lesions of Syphilis." Sidney Olansky and Lawrence E. Putnam. The Journal of Venereal Disease Information, July 1946.

"Homologous Serum Jaundice; Experimental Inactivation of Etiologic Agent in Serum by Ultraviolet Irradiation." John W. Oliphant and Alexander Hollaender. Public Health Reports, April 26, 1946.

"How Does Housing Affect Health?" M. Allen Pond. Public Health Reports, May 10, 1946.

"Shadowed Replicas of Tooth Surfaces." David B. Scott and Ralph W. G. Wyckoff. Public Health Reports, May 17, 1946.

"The Role of Nutrition in Preventive Medicine." F. F. Tisdall. The Milbank Memorial Fund Quarterly, January 1945.

"The Preparation of Antigens from Yolk Sacs Infected with Rickettsiae." Norman H. Topping and Charles C. Shepard. Public Health Reports, May 17, 1946.

"A Method for the Preparation of Tsutsugamushi (Scrub Typhus) Antigen from Infected Yolk Sacs." Norman H. Topping and Charles C. Shepard. Public Health Reports, May 31, 1946.

"Cardiovascular Disease among Veterans of World War II; a Survey of 19,870 Cases." Aaron H. Traum and Blanche B. Wilcox. New England Journal of Medicine, January 17, 1946.

"Studies on Marihuana and Pyrahexyl Compound." Edwin G. Williams, C. K. Himmelsbach, Abraham Wikler, Dorothy C. Ruble, and Bolivar J. Lloyd, Jr. Public Health Reports, July 19, 1946.

"The Increase in Tuberculosis Proportionate Mortality among Nonwhite Young Adults." J. Yerushalmy. Public Health Reports, February 22, 1946.

JOHN WILLIAM WARNER, B.A., M.D., F.A.C.S.

(1883–1946)

Dr. John William Warner, head of the Department of Gynecology and Obstetrics of Doctors Hospital, and one of the leading gynecologists in Washington for the last 25 years, died October 29 at his home, 3409 Lowell Street, N.W., after a long illness.

Born in Rockville, Maryland, on May 5, 1883, Dr. Warner was the son of John W. and Mary S. Warner and the brother of the Reverend Charles T. Warner, D. D., Rector of St. Alban's Parish. After graduating from the Rockville Academy, he attended Washington and Lee University, where he received his B. A. degree in 1903. He taught school for two years in Charles Town, West Virginia, before resuming his studies at the College of Physicians and Surgeons in New York City. After his graduation in 1909 he took his internship at Bellevue Hospital and then was appointed assistant gynecologist at Roosevelt Hospital in New York where he was associated with Dr. Howard S. Taylor.

Commissioned a First Lieutenant in the U. S. Army Medical Corps in 1916, Dr. Warner saw active service in France for more than a year with the Field Hospital of the Fifth Division, and retired with the rank of Major. He was awarded the Verdun Medal.

He came to Washington in 1920 and was in active practice here, with offices at 1835 Eye Street N. W., until a few months ago. In addition to his duties at Doctors Hospital, he was on the staffs of Emergency and Georgetown Hospitals.

He was a Fellow of the American Medical Association, the American College of Surgeons, and the New York Academy of Medicine; an Active member of the Medical Society of the District of Columbia for 26 years; Past President of the Washington Gynecological Society; and a member of the Chevy Chase, Army and Navy and Rotary Clubs, and Delta Tau Delta fraternity. He was a member of St. Alban's Parish and had been Treasurer of the Sunday School for many years.

Surviving is his wife, Mrs. Martha S. B. Warner, and two sons, John W., Jr., a student at Washington and Lee University, and Charles Stewart, who attends Landon School.

MILTON HICKOX PROSPERI, M.D.

(1878–1946)

Dr. Milton H. Prosperi, for more than forty years a practicing physician in Washington, died suddenly, November 11, 1946, at his home at 216 8th Street, S. E.

Dr. Prosperi was born in Washington, D. C., May 14, 1878, the son of the late Charles and Mary Josephine Prosperi. His mother was one of the first music teachers of John Philip Sousa. An accomplished pianist himself, Dr. Prosperi composed many pieces for the Marine and Navy Bands.

He attended the District schools and graduated from Columbian Medical School (now George Washington University School of Medicine) in 1904. He began practicing medicine the same year.

For a number of years he was Chairman of the Board of Directors of the American Building Association.

He was a Fellow of the American Medical Association, an Active member of the Medical Society of the District of Columbia since 1906, and a member of George Washington University Medical Society. Active in Masonic affairs, he was a member of the Knights Templar, the Scottish Rite and the Shrine.

His wife, Mrs. Irvel S. Prosperi, survives him together with a brother, William H. Prosperi, of Washington.

Tumors of Lymphoid Tissues—Spier and Cluff

(Continued from page 595)

of chronic infectious drainage, may have some relationship to the causal agents of these tumors. All of these statements and observations are merely conjectures, and further evidence is necessary to show direct correlation between any of them and neoplasia.

Summary

A classification and discussion of lymphoid tumors is presented, with complete morphologic descriptions of each. A review of the literature concerning these diseases was made and suggestions for etiology have been outlined.

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Cancer of Colon—Geier

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Footnotes—Observer

(Continued from page 620)

out, "the full resources of the largest and most influential group among the 15,000,000 American veterans" is now definitely on organized medicine's side. . . . Dr. Robert H. Groh, General Chairman of the Committee on Arrangements for the 18th Annual Scientific Assembly, announces that the coming Assembly has been scheduled at the Hotel Statler, Washington, on October 6, 7 and 8. . . . At a recent public health meeting, one of the friends of the Medical Society drily observed that if the present increase of mental cases continues, normal individuals will be a decided minority. They might as well move into mental hospitals, he said, and let the patients care for them. . . . Last month, Dr. Sterling V. Mead, President of the American Dental Association and an Associate member of the Medical Society, was a victim of a zany suggestion. Broadway columnist, Dorothy Kilgallen, whose dissertations appear daily in the *Washington Times-Herald*, concluded her column recently by asking her readers, "And did you know that if you dial NERVOUS on the telephone you get the right time?" Now, Miss Kilgallen is a resident of New York, where her column is also published. Readers failed to note that she had reference to New York telephones. Many people dialed NERVOUS on Washington's six-unit system, and were connected with NERVOU, or ME. 7868, a public telephone located in Dr. Mead's dental hospital. The result was that the hospital's office staff was swamped with calls day and night for several days. Not knowing the reason for these calls, the staff notified the telephone company, which, too, was unaware of what was going on. The telephone switchboard was taken apart to see if it was functioning properly. Callers gave no hint as to why they were calling, merely hanging up when informed they were connected with a dental hospital. At last it came out when an inquirer asked what time it was. NERVOU is now a "dead" line.

T. W.

Medical Care Plans—Hendricks

(Continued from page 622)

prepayment medical care of hospital services to their members. Now listed are 99 such plans in 31 states with an estimated 559,000 persons covered, with no enrollment estimates on 28 of the plans. It is hoped that information on how they operate, the services offered, number of persons covered, cost data and other information may be obtained.

Second, the National Bituminous Coal Mine Wage Agreement. Significance of the agreement between Government and the United Mine Workers of America which places health and medical services under Union control is becoming increasingly apparent. It has been estimated that the miners' welfare and retirement fund obtained from a five cent impost on each ton of coal mined will be more than $30,000,000 annually. This will be in addition to medical and hospital funds created by check-off from miners' pay. Services now rendered in mine areas are largely on a prepayment basis. A health and medical service survey of these areas has been concluded by the Navy and the report by Rear Admiral Joel T. Boone, M. C., U. S. N., may be expected shortly. Dr. Walter B. Martin, of Virginia, a member of the Council, has served as chairman of several meetings with mine physicians and the Navy to consider this subject.

How many people can ultimately be covered by this voluntary program? Seventy million persons now carry life insurance. With proper timing and teamwork, organization, publicity, and public relations, why shouldn't at least as many be covered by voluntary health insurance, if the forces of organized medicine, insurance, and Blue Cross can be coördinated?

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